A STUDY TO DETERMINE THE BEST APPROACH FOR CONDUCTING A FORMAL AMBULATORY SURGERY PROGRAM AT WILLIAM BEAUMONT ARMY MEDICAL CENTER EL PASO, TEXAS

A Graduate Research Project

Submitted to the Faculty of

Baylor University

In Partial Fulfillment of the

Requirements for the Degree

of

Master of Health Administration

by

Major Harold C. Koehler, MSC

May 1982

SECURITY CLASSIFICATION OF THIS PAGE

REPORT DOCUMENTATION PAGE

Form Approved OMB No. 0704-0188

1a. REPORT SECURITY CLASSIFICATION Unclassified	1b. RESTRICTIVE MARKINGS
2a. SECURITY CLASSIFICATION AUTHORITY	3. DISTRIBUTION/AVAILABILITY OF REPORT Approved for public release; Distribution unlimited
2b. DECLASSIFICATION/DOWNGRADING SCHEDULE	
4. PERFORMING ORGANIZATION REPORT NUMBER(S) 14-88	5. MONITORING ORGANIZATION REPORT NUMBER(S)
6a. NAME OF PERFORMING ORGANIZATION US Army-Baylor University Graduate Program in Health Care Admin/HSHA-IHC 6b. OFFICE SYMBOL (If applicable)	7a. NAME OF MONITORING ORGANIZATION
6c. ADDRESS (City, State, and ZIP Code) FT Sam Houston, TX 78234-6100	7b. ADDRESS (City, State, and ZIP Code)
8a. NAME OF FUNDING/SPONSORING ORGANIZATION 8b. OFFICE SYMBOL (If applicable)	9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER
8c. ADDRESS (City, State, and ZIP Code)	10. SOURCE OF FUNDING NUMBERS PROGRAM ELEMENT NO. / PROJECT NO. / TASK NO. / WORK UNIT ACCESSION NO.

11. TITLE (Include Security Classification)
A STUDY TO DETERMINE THE BEST APPROACH FOR CONDUCTING A FORMAL AMBULATORY SURGERY PROGRAM AT WILLIAM BEAUMONT ARMY MEDICAL CENTER, EL PASO, TEXAS

12. PERSONAL AUTHOR(S)
MAJOR HAROLD C. KOEHLER

13a. TYPE OF REPORT	13b. TIME COVERED	14. DATE OF REPORT (Year, Month, Day)	15. PAGE COUNT
Study	FROM JUL 81 TO MAY 82	MAY 82	149

16. SUPPLEMENTARY NOTATION

17. COSATI CODES			18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)
FIELD	GROUP	SUB-GROUP	AMBULATORY SURGERY PROGRAM; SAME-DAY-SURGERY

19. ABSTRACT (Continue on reverse if necessary and identify by block number)

This study examines the appropriate mechanisms needed to implement a formal Ambulatory Surgery Program within a military health care facility.

Keywords: outpatient care; surgery; ambulatory care; medical services; minor surgery; hospitals; theses; (KT)

20. DISTRIBUTION/AVAILABILITY OF ABSTRACT	21. ABSTRACT SECURITY CLASSIFICATION
☒ UNCLASSIFIED/UNLIMITED ☐ SAME AS RPT. ☐ DTIC USERS	
22a. NAME OF RESPONSIBLE INDIVIDUAL Lawrence M. Leahy, MAJ(P), MS	22b. TELEPHONE (Include Area Code) (512) 221-6345/2324
	22c. OFFICE SYMBOL HSHA-IHC

DD Form 1473, JUN 86 Previous editions are obsolete. SECURITY CLASSIFICATION OF THIS PAGE

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ACKNOWLEDGEMENTS

I wish to express my sincerest appreciation to Mrs. Dixie Meyers who dedicated many long hours to editing and typing this manuscript. Her able assistance made the task of producing this work far simpler. One of the major highlights of my Administrative Residency has been the opportunity to work with such a patient, competent, and productive individual.

I am truly indebted to Colonel Lewis M. Edwards, the WBAMC Executive Officer, for his sound guidance and kind encouragement. I am thankful for the opportunity to have served under such a qualified administrator and effective leader.

To Colonel Thomas M. Geer I wish to express my thanks for providing the initial guidance in planning this project. My one regret is that I was not able to work with him longer prior to his departure for Fort Lee, Virginia.

Ms Terri Beam of the Special Studies Branch, Patient Administration and Biostatistics Agency, Fort Sam Houston, Texas, deserves a special thanks for her valuable assistance in workload data retrieval, and her keen interest in this study.

Other persons making notable contributions are: Colonel Warren N. Otterson, Chief of Professional Services; Colonel Daniel G. Cavanaugh, Chief, Department of Surgery; Colonel Donald A. Vichick, Chief, Department of Orthopaedics; Captain Mark A. Lenneville, Administrator, Walter Reed Army Medical Center Ambulatory Surgery Center; Mrs. Monique Jackson, Registered Records Administration, Patient Administration Division.

I. INTRODUCTION

Historical Perspective

Major changes to improve quality of health care and to contain costs through more efficient use of available resources are taking place within the health care industry in the United States. The concept of ambulatory surgery has become widely accepted in the past decade, and has provided an effective means of containing costs. This concept is neither new nor revolutionary, but has been in existence since the turn of the century. The first published report of ambulatory surgery appeared in the British Medical Journal in 1909, when Dr. J.H. Nichol reported on 7,320 operations he had performed on ambulatory patients at the Royal Glasgow Hospital for Children.[1]

In spite of early successes in ambulatory surgery, the concept was slow to gain wide acceptance. By the late 1930's, as medicine advanced and specialization increased, the medical profession concentrated on performing surgical procedures in an acceptable hospital and discouraged surgery done outside the hospital environment. After World War II the specialty of anesthesiology experienced an explosive growth rate. Anesthesiologists, by the nature of their specialty, must work in the hospital environment; thus, the movement toward centralization of surgical services within the hospital was accelerated. The results of this movement was to create a public impression that first class surgical therapy could only be carried on in the confines of the hospital.[2]

As medical knowledge and technology expanded, the demand for health care service increased. With the proliferation of third party payment mechanisms, particularly the introduction of the MEDICARE and MEDICAID programs in the mid-1960's, both the demand and the cost of health care experienced tremendous annual increases. The majority of each health care dollar has been taken by hospital costs. As a result of this cost dilemma, health care managers began to search for more efficient alternatives, and the resurgence of ambulatory surgery became one of the inevitable products.

Probably the single most important factor which has led to the wide acceptance of ambulatory surgery in the health care industry is the tremendous improvement of anesthetics. The pharmaceutical industry has developed anesthetics that act rapidly and leave the patient with minimal prolonged side effects. In addition, the availability and use of short-acting narcotic and non-narcotic analgesics to treat pain, and drugs to manage nausea and vomiting, have reduced patient discomfort. In addition to pharmaceutical advancements, surgeons are now encouraging patients to become ambulatory sooner after surgery, which results in decreased recovery time.[3] This relatively new thinking has further encouraged the use of ambulatory surgery.

In 1980 the American Hospital Association (AHA) conducted a survey to determine the prevalence of ambulatory surgery in the United States. The survey was mailed to all non-federal hospitals in 134 of the largest metropolitan areas, which represented approximately 50 percent of all hospitals in the United States. Of the hospitals surveyed, 70 percent (1,506) stated that they offered ambulatory surgical services of some type.

Of these, 54 percent (803) stated they had organized ambulatory surgery programs. It was noted that there appears to be more of a tendency for a hospital to organize such a program as the number of hospital beds increase. The survey further showed that 18 percent of all surgery conducted in hospitals having ambulatory surgery facilities was done on an outpatient basis.[4] There is no consensus as to the percentage of all surgical procedures that could be conducted in this mode. Various authors have estimated that about 20 to 40 percent of all surgery performed in the United States today could safely be accomplished on an ambulatory surgical basis.

There is no question of the importance of ambulatory surgery in our current health care delivery system. In the past few years the American experience with this concept has increased dramatically. Based on current trends, it is widely predicted that the practice of ambulatory surgery will continue to increase in popularity.

Definitions Relevant to Ambulatory Surgery

Ambulatory surgery has been termed "same-day surgery," "outpatient surgery," "in-and-out surgery," and "short stay surgery." For the purposes of this research project the American Hospital Association's definition of ambulatory surgery will be used. It is:

> Scheduled surgical procedures provided to patients who do not remain in the hospital overnight.[5]

Although surgery is often performed in a variety of places outside the main operating room (OR), such as the physician's office, various outpatient clinics, and in emergency departments, this study will not specifically address those procedures currently being done in such areas.

Only those procedures being done on an inpatient basis that could be performed on an outpatient basis in a program designed to provide scheduled surgical procedures to outpatients will be addressed.

Questions Raised Regarding Ambulatory Surgery

The primary question raised when ambulatory surgery is first being considered by a hospital is whether the addition of this service will decrease the demand for hospital beds, or increase workloads because of existing backlogs and unmet demands for more complicated procedures. Stated another way, would Roemer's Law come into effect where an increase in supply would create an increase in demand for health care resources? Naturally the answer to this important question can only be determined by extensive forecasting studies and/or empirical measurement once such a project is implemented.

Major subjective variables which must be considered are the levels of acceptance of such a program by both physicians and patients. Closely associated with the acceptance question is number and types of surgical procedures that physicians will agree to perform in an ambulatory surgery setting. Numerous lists of surgical procedures which are performed in this setting have been published by various sources. One such list of common operative procedures in ambulatory surgery published by O'Donovan[6] shows approximately 280 different procedures.

Another question raised concerns the cost of implementing an ambulatory surgery program. Although many articles can be quoted which substantiate the direct cost savings to the patient and third party payors, the overall economic impact on a given hospital or a specific area would

require a careful study prior to implementation of ambulatory surgery. The primary issue in the civilian sector is the overall effect on the patient census when ambulatory surgery is practiced. In communities where existing facilities are already over-burdened with a demand for surgical services, such programs would most likely provide valuable relief at a lower cost. In communities where demand for surgical services is insufficient to fill available hospital beds, the addition of such facilities may exacerbate the hospital's financial problems.[7] Regardless of the setting, one fact remains: ambulatory surgery is less expensive for many patients.

In studying the effects of ambulatory surgery, it is important to separate the measure of successes between the financial and the medical aspects. A program may be medically successful if it can prove that it achieves all of its objectives, while at the same time it may be financially unsuccessful. The explicit objective of any health care program is the delivery of quality health care to patients; an implicit objective is to remain financially viable in order to continue rendering such care.[8]

The overall question of cost is a matter of perspective. In the civilian sector financial profitability is the dominant factor. While cost containment, or the efficient use of resources, is an important factor in the military sector, there is probably less incentive for military commanders of hospitals to reduce services or to substitute outpatient services for inpatient services in the name of cost efficiency. The idea of ambulatory surgery presents the perfect example of this lack of inducement. Using the existing workload measurement of the Medical Care Composite Unit (MCCU), which provides a major driving force for funding, a hospital admission provides approximately 30 times the workload credit of an

ambulatory visit. Consequently, the commander's major incentive is to insure that admissions remain high, and beds remain filled in order to justify next year's budget.

Another cost perspective related to the question of overall demand for ambulatory surgery is that of personnel staffing. In the civilian sector, staffing positions can generally be created or abolished rather quickly, dependent upon need. Within the military environment, however, staffing changes require a great deal more bureaucratic red tape. If the decision to implement ambulatory surgery requires the performance of a greater workload using only existing staff, i.e., the "take it from your hide" approach, then implementing ambulatory surgery in a military hospital may prove to be a very unpopular alternative, particularly for the nursing staff.

A final question relates to the quality of care. Supporters of ambulatory surgery have pointed out that a large number of procedures can be carried out under general anesthesia on a same day basis with no detriment to the patient. While cost issues are far from clearly resolved, there appears to be a greater consensus regarding quality in ambulatory surgery. Davis states that physicians should regard ambulatory surgery as not only being cost-effective medicine, but good medicine.[9] If we are to assume that this preliminary evidence is correct, and that it is possible to maintain or even improve the quality of surgical care by use of the ambulatory setting, then the primary issue that remains is how to implement appropriate mechanisms to insure that high quality is continuously maintained.

Factors Prompting This Study

William Beaumont Army Medical Center (WBAMC) is a 463-bed hospital that serves an active duty, retired, and dependent population of approximately 140,000. Located adjacent to Fort Bliss, Texas, WBAMC has one of the largest patient care workloads of any Army medical treatment facility. In addition to the primary mission of patient care, WBAMC also conducts numerous graduate medical education programs, including a large medical internship program and residencies in Internal Medicine, Pediatrics, Obstetrics/Gynecology, Orthopaedics, Pathology, and General Surgery. Phase II of the Academy of Health Sciences U.S. Army Anesthesiology for Nurse Corps Officers and the Operating Room Nursing Course are also conducted.

Approximately 450 operative procedures are done monthly at WBAMC. Facilities exist to accommodate a very wide range of surgical procedures. There are eight operating rooms located in the main operating suite. Six to seven of these rooms are in use at any time during normal operating hours. Present surgical staffing is for seven operating rooms on weekdays until 1500, and two rooms at all other times.

The fact that ambulatory surgery has been widely acclaimed in the civilian health care industry, and yet not widely practiced in the Army in an organized fashion, opens the questions of not only why isn't this more popular, but how can such a service best be conducted by a military hospital? It is evident that a properly structured program could improve efficiency at WBAMC. Therefore, the purpose of this study is to determine the best approach for implementing an ambulatory surgery program. It should be noted that any model to be developed herein would be relevant

in many ways for other Army MEDDACs and MEDCENs, because of the great similarities that exist in mission and population served.

Limitations to the Study

The most severe limitation to this study is the lack of an established and uniform cost accounting system that is capable of isolating and identifying direct and indirect costs for selected surgical patients in Army facilities. While the Uniform Chart of Accounts (UCA) provides useful information for identifying overall costs, only generalized conclusions regarding cost effects from ambulatory surgery can be rendered. It is therefore not feasible to conduct a cost-benefits analysis that provides a totally accurate financial impact to be derived by implementing ambulatory surgery.

A second major limitation to this study is the inability to determine the actual staff manpower required for various types of surgical patients; therefore, manpower savings from ambulatory surgery cannot be accurately predicted. When the Uniform Chart of Accounts, Personnel (UCAPERS) becomes fully operational, such data may increase the level of sophistication possible for studying staffing impacts of ambulatory surgery.

A third limitation is the availability of nursing staff to operate additional nursing facilities. At present, the WBAMC Nursing Service, like most in other Army hospitals, faces an overall nursing staff shortage. To remove nurses from other services to staff ambulatory surgery areas is not likely; therefore, implementation of such a service will require requesting additional space allocations. This limitation was

imposed by the WBAMC Chief of Professional Services. One assumption of this study is that if implementation of ambulatory surgery actually results in a decreased inpatient census, some additional nursing staff could be shifted from other duties to assist in the program. Conceivably, the implementation of this concept could eventually allow for an overall nursing staff reduction. Considering existing staff shortages, the probable effect would be to allow the Nursing Department to fill other patient care areas experiencing critical shortages.

The final limitation is that no construction will be possible to separate a proposed ambulatory surgery program from existing surgical facilities. Because of this, any model proposed must use the main operating room and other existing treatment/diagnostic facilities.

FOOTNOTES

[1]M. Robert Knapp, "Ambulatory Surgery," Medical Group Management, Sep/Oct 1979, p, 51.

[2]Ibid, p. 51, passim.

[3]Linda A. Burns, Mindy S. Ferber, "Ambulatory Surgery in the United States: Development and Prospects," The Journal of Ambulatory Care Management, Vol 4, No. 3, Aug 1981, p. 2.

[4]Ibid.

[5]Lecture given by Mindy S. Ferber, American Hospital Association, Division of Ambulatory Care, to the AHA seminar titled, "Ambulatory Surgery: Implementing and Managing a Successful Hospital Program," Minneapolis, MN, 29 October 1981.

[6]Thomas R. O'Donovan, ed., Ambulatory Surgical Centers Development and Management, Germantown, MD: Aspen Systems Corporation, 1976, Appendix C, pp. 203-207.

[7]Michael J. Goran and Magruder C. Donaldson, "Role of the Federal Government in Ambulatory Surgery: Implications of Quality Assurance," Ambulatory Surgical Centers Development and Management, Thomas R. O'Donovan, ed., Germantown, MD: Aspen Systems Corp., 1976, p. 144.

[8]Allen Weltman, "Cost Determinations and Constraints in Ambulatory Surgery," Ambulatory Surgical Centers Development and Management, Thomas R. O'Donovan, ed., Germantown, MD: Aspen Systems Corp., 1976, p. 158.

[9]James E. Davis, "Developing the Ambulatory Surgical Unit: The Physician's Responsibility," The Journal of Ambulatory Care Management, Vol 4, No. 3, Aug 1981, p. 34.

II. DISCUSSION

Impact on Costs and Efficiency

As the subject of ambulatory surgery has become one of great interest in the health care field, various questions have been raised as to its economic effect. While direct cost savings can be demonstrated at the institutional level, the same is not clearly evident at the national level. Whether money will ultimately be saved by widespread incorporation of ambulatory surgery will be largely dependent upon such complicated variables as reimbursement policies of third party payers, availability and need of surgical services, pricing behavior of hospitals, capital costs, and changing styles of medical practice.[1] Variables that affect savings at the national level must be molded to stimulate sound planning and implementation of ambulatory surgery at community and institutional levels.

Demands for cost containment, efficiency, and high-quality services will not abate. To ignore these forces is to invite greater problems for the future. Ambulatory surgery is worthy of serious consideration because of the proven cost savings numerous hospitals have realized. Grossman maintains the crux of the entire cost savings issue is not whether ambulatory surgery should be performed, but where it should be performed.[2] If there is a community need for additional surgical capacity, separate facilities should be constructed for ambulatory surgery. Where excess surgical capacity is available, existing hospital facilities could be utilized for implementing this concept.

Unfortunately the military sector is far behind the civilian health care industry in implementing organized ambulatory surgery programs. As noted earlier, the lack of incentives is probably due to the workload accounting system, which provides little stimulus to treat patients on an outpatient basis. The idea of implementing any program that proposes to remove patients from hospital beds and decrease MCCU credits has naturally received little serious consideration from military managers. The most often expressed criticism regarding the MCCU formula is that a relatively simple accounting system is imposed upon a very complex medical delivery system, and levels of intensity in resource expenditures are not properly credited.

It has been proven that introduction of ambulatory surgery can actually increase total beds occupied in some areas. More important, total productivity of a hospital can be significantly increased with expenditure of only limited additional resources. Crouse-Irving Memorial Hospital of Syracuse, New York, increased total percentage of bed occupancy from 82 to 92 percent in four years following implementation of ambulatory surgery.[3] It can be concluded that hospitals experiencing nursing staff shortages resulting in surgical backlogs due to lack of beds, can greatly benefit from this concept. Ambulatory surgery can free needed hospital beds for patients requiring more complicated surgical procedures. The average length of stay (LOS) for patients actually occupying beds will increase under such circumstances.

Proponents of ambulatory surgery usually cite efficiency as its principal merit. Providing a specific amount of surgical services, defined as "appropriate" by surgeons, at the least possible overall cost, is of

vital importance to cost containment.[4] The specific responsibility of health care managers is to insure optimum productivity of resources under their control. Drucker points out that increase of productivity is, in part, achieved by innovation, or the shift from old and declining resources to those that are new and productive.[5] In this context it is clear that the inpatient treatment of certain categories of surgical patients for elective or minor procedures may represent obsolete, unproductive, and wasteful medical practice.

Military administrators must develop ambulatory surgery models to fit the needs of the military population. These programs must be formulated in a fashion that will efficiently generate the MCCU credits necessary to justify any losses that might be incurred elsewhere. Hospital commanders must be provided necessary incentives to shift resources and funding to accommodate such programs.

Quality Assurance in Ambulatory Surgery

Ambulatory surgery has been proven to be not only an efficient, but a safe form of medical practice. The Freestanding Ambulatory Surgical Association, which represents about 100 members, recently reported on results of surgical procedures performed in 36 freestanding facilities. This report showed that nearly a half million procedures had been performed with no fatalities. Patients transferred to hospitals numbered 233; 89 were unanticipated; and eight were emergency transfers.[6]

An extensive study by Natof found that of 13,433 patients treated at a freestanding center, only 106 medical, surgical, and anesthetic complications occurred. Of these, 16 patients required hospitalization.

There was no report of cardiovascular collapse or death. The study concluded that many surgical procedures can be performed safely in the outpatient setting.[7]

In February 1981, the Board of Regents of the American College of Surgeons issued a statement regarding ambulatory surgery. A portion of this statement follows:

> . . . the American College of Surgeons approves the practice of performing certain operative procedures in ambulatory surgical facilities, provided that appropriate quality assurance measures are in force. Of prime concern is the patient's suitability for ambulatory surgery as well as the provision of proper standards for physician privileges and facility accreditation.[8]

The WBAMC Quality Assurance Program (QAP) provides necessary mechanisms to monitor quality of care provided in the proposed program. Quality of care provided will be equal to that provided inpatients. Expected patient outcomes proposed as program standards are:

1. Surgical procedures shall be performed safely and accurately by qualified personnel.

2. Procedures will be coordinated in such a way as to provide for accuracy of scheduling and efficiency of time for the patient, staff, and physician.

3. The physician will insure that the patient adequately understands the procedure to be performed, and suffers no undue anxiety from lack of knowledge.

4. The patient must understand his/her responsibilities of self-care both before and after the procedure.

5. The patient, or a responsible party, must know exactly what untoward signs or symptoms to watch for after discharge, and what action to take should complications develop.

6. Qualified personnel shall be available at all times to answer the patient's questions.

7. The patient must understand what prescribed drugs are for, when to take them, and what precautions to observe when taking these drugs.

8. The patient must be assured of safety in traveling home following discharge.

9. The privacy of the patient must be provided for and respected.

10. The patient's valuables and personal effects must be maintained in a secure area until discharge.

11. The patient will be treated as a unique individual with the respect and dignity which is recognized as a fundamental right of every patient entering WBAMC.[9]

Models for Ambulatory Surgery

The primary tasks of health care managers involved in the planning and development of ambulatory surgery programs is to gain a good understanding of the basic concepts, then conduct a functional analysis of how such a program can best be performed in a particular setting. Much useful information can be gained from reviewing various ambulatory surgery models that have been implemented.

Two basic models of ambulatory surgery exist: those that utilize existing hospital main operating room (OR) and recovery facilities (hereafter termed the "integrated model"); and those where surgery is performed in separate facilities specifically created for such a purpose, either on or off the hospital campus, (hereafter termed the "freestanding model").[10] Although ambulatory surgery can take place in many settings, the most common is the hospital.[11]

Several different forms of the integrated model have evolved. Some hospitals have developed rather formal programs which utilize a separate nursing unit for the reception, processing, recovery, and discharge of the patient. Other hospitals have totally integrated these patients with

other surgical patients. In this less formal setting, patients are discharged directly from the recovery area when they have recovered sufficiently from the anesthesia. Although such patients are treated on an outpatient basis, some hospitals may do a "paperwork admission."

The most obvious advantage of the integrated model is that ambulatory surgery capability can be established without making large capital expenditures for new construction. This means that services can be more quickly established. Many economies are realized when inpatient facilities can be utilized for outpatient procedures. When surgery is performed in the hospital, surgeons can do more complex procedures because extensive diagnostic and treatment resources are readily available for use. For example, if the pathology report on a breast biopsy shows cancer, more definitive surgery could be performed at that time rather than waiting until the patient could be transferred to the inpatient area of the hospital.[12]

Berkoff notes that the potential for sharing of medical ancillary support services in a hospital setting is a mixed blessing. Such sharing arrangements usually create complex circulation patterns and complicate the organization of an efficient ambulatory surgery unit.[13]

The introduction of ambulatory surgery cases into already busy main ORs makes scheduling more difficult. Those responsible for scheduling may consider these procedures of lower priority since they are minor or elective. Ambulatory cases must be scheduled during morning hours to allow sufficient time for the recovery and discharge of patients that same day. This can produce conflict since surgeons consider morning hours as prime time for performing their surgical procedures.

Bumping, or rescheduling of surgery cases, can be a major obstacle in development of an effective integrated model. Bumping is a problem at WBAMC due to procedures taking longer than scheduled, or because of emergency procedures taking precedence over scheduled cases.[14] Insuring that ambulatory cases are sequentially scheduled in a particular OR would certainly increase overall productivity of the OR suite and should reduce bumping of these cases.

The turn-around times of rooms between cases in the main OR area are necessarily longer than in a freestanding model since more complex cases are mixed with ambulatory cases. Minor cases usually involve less surgical equipment; therefore, turn-around times in freestanding models are ordinarily as short as ten to fifteen minutes. Although no studies have been done at WBAMC, time between cases is thought to be much longer. A planning turn-around time of 30 minutes would be fairly accurate. The fact that WBAMC conducts extensive training programs in the ORs would also be a prominent factor. Students normally require longer times to perform cleaning and set up tasks than experienced staff members.[15] Integrated models are generally less efficient than freestanding facilities since they are not tailored specifically to minor or elective procedures; therefore, fewer cases can be expected to be completed during a given time.

Another problem of the integrated model involves perceptions of the surgical and recovery staffs toward ambulatory patients. These staff members are routinely involved in complex surgery cases and may consider minor cases less interesting and perhaps not worthy of the same attention. Ambulatory surgery patients, particularly those receiving a general anesthestic, require rather intense care, even if only for a short time. Every

effort must be made to insure that the special needs of these patients are understood by staff members.

The integrated model may not lend itself to an overall increase in total number of surgical cases performed in the main ORs if a full surgical workload already exists. The size of the assigned OR and recovery nursing staffs and the physical space available in recovery areas for bed expansion, are primary limiting factors which could preclude an increase in the number of surgical cases. Establishment of an integrated model will reduce existing surgical backlogs only if added effort is made to improve scheduling procedures and reduce turn-around times between cases.

The freestanding model represents a much larger investment of resources for ambulatory surgery. A much more efficient service can be provided when separate facilities are designed for this concept. The freestanding model tends to alleviate those disadvantages noted in the integrated model. Because this model is tailor-made, the many complexities in integration of ambulatory cases with other surgical cases are eliminated. Scheduling complications are greatly reduced and more cases can be completed per day in each freestanding OR since most minor procedures, with the possible exception of some plastic surgery cases, are of short duration with shorter turn-around times. Probably the greatest advantage of the freestanding model is the creation of a larger surgical capability. A greater number of surgical procedures can be accomplished without imposing a corresponding burden on the main OR and recovery staffs. Where there is an unmet demand for more complicated surgical procedures, additional main OR time and nursing beds are made available for such purposes. Because the nursing and administrative staff necessary to operate the freestanding

facility is small and appropriately proportioned for the specific mission, greater capacity is realized with a relatively small staff increase.

The greatest disadvantage of the freestanding model is the rather large capital investment required to design and build a new facility. A thorough marketing analysis is required to insure sufficient justification for this type venture. Kraft maintains that at least 2000 cases per year must be projected before this model should be considered.[16] A related disadvantage is the longer time required to implement ambulatory surgery when the freestanding model is selected. In the military sector, where construction projects face a long and involved bureaucratic process for approval, implementation of ambulatory surgery from a freestanding facility could take many years. Under such circumstances the only feasible alternatives for many military hospitals may be incorporating the integrated model or reallocation of existing space to house a freestanding service.

Selection of Patients

Generally speaking, ambulatory surgery is concerned with minor procedures which do not constitute a hazard to the patient.[17] Appendix A provides a list of ambulatory surgery procedures performed by various surgical specialties.[18] Typical cases are nonemergent, noninfected, and elective. While the rate will vary greatly among hospitals, a large proportion of these cases performed in existing programs are done under general anesthesia. Such procedures are usually of short duration, often less than one hour, and require less than a two-hour stay in the recovery room.[19]

Lieberman, et al., maintains that ambulatory surgery is based on two well-tested premises:

1. A large variety of minor surgical procedures, either emergency or elective, do not require overnight post-surgical care and observation.

2. It is rarely necessary for such a patient to remain overnight in the hospital solely for post-anesthesia care and observation.[20]

The following American Society of Anesthesiologists patient classification system provides a useful guide in selecting patients for ambulatory surgery:

Class I. A normal healthy patient for an elective operation.

Class II. A patient with a mild systemic disease.

Class III. A patient with a severe systemic disease that limits activity but is not incapacitating.

Class IV. A patient with an incapacitating systemic disease that is a constant threat to life.[21]

As a general guideline, the majority of Class I and Class II patients can be considered candidates for ambulatory surgery. The Surgicenter at Walter Reed Army Medical Center accepts both classes of patients into their program.[22]

Patients who are to undergo this type of surgery must make arrangements to be transported home and to have a responsible adult remain with them for a period of approximately 24 hours. Single, active duty soldiers residing alone or in the barracks are not good candidates for the program, nor are patients who must commute long distances to the hospital.

Other Class I and Class II patients who should not be considered for ambulatory surgery are:

1. Patients who are below the average range of intelligence or senile. Retarded children or adults under the close supervision of their families can be an exception.

2. Patients with severe character disorders, especially alcoholics and other drug abusers.

3. Uncooperative, hostile, or litigious patients.[23]

Planning the Feasibility Study

In development of the feasibility study as it relates to ambulatory surgery at WBAMC, the first step is to establish strategic goals for such a program. Some goals considered by civilian hospitals are:

1. Maintain current market share.
2. Develop new markets.
3. Maintain/generate revenue.
4. Increase inpatient treatment efficiency.
5. Attract/maintain physicians.[24]

The primary goal recommended for WBAMC's proposed program is to improve efficiency by removing certain classes of surgical patients from inpatient rolls. This must be done without significantly degrading the funding level of the medical center. A second goal is insuring that high quality assurance standards are continually maintained. The heuristic approach will be used in formulating the proposed model since a similar program does not exist, and because of multiple variables which must be considered.

The three basic components of a feasibility study are (1) market and (2) internal assessment, both of which are used for forecasting utilization levels; and (3) financial projections.[25] Market assessment will not be addressed for this study as WBAMC's catchment area is well-defined and no market competition exists.

Internal assessment can best be accomplished through use of a questionnaire designed to solicit information regarding types of procedures presently being performed that may lend themselves to surgery in the outpatient mode. It is also useful to gain some insight as to probable level of physician acceptance that can be anticipated.

Based on input from staff physicians, demand forecasts can be developed by retrieval of WBAMC workload data from the Army's Individual Patient Data System (IPDS)(RCS MED-345). The Uniform Chart of Accounts (UCA) can be used to develop generalized financial projections.

Development of the Demand Forecast

Determination of probable types and numbers of surgical procedures that would be performed in the proposed program was accomplished by a study of past workload data for selected procedures. Key staff physicians were provided a list of surgical procedures and a short questionnaire (Appendix B). The questionnaire was purposely kept very brief to increase the probability of physician response. Questionnaires were forwarded to the following individuals with 100 percent response:

Chief, Department of Surgery (information only)
Chief, Department of Obstetrics/Gynecology
Chief, Department of Orthopaedics
Chief, Ear, Nose, and Throat Service
Chief, General Surgery Service
Chief, Neurosurgery Service
Chief, Ophthalmology Service
Chief, Peripheral Vascular Surgery Service
Chief, Plastic Surgery Service
Chief, Urology Service
Chief, Oral Surgery Service

Following a review by the Chief, Department of Surgery, the list of procedures recommended by the respondents was coded in the International

Classification of Disease, 9th Revision, (ICD-9) format by the Medical Records Administration Section of WBAMC Patient Administration Division. The coded procedures were then forwarded to the Special Studies Support Branch of the Patient Administration Systems and Biostatistics Agency (PASBA), Fort Sam Houston, with a request for retrieval of WBAMC workload data (Appendix C).

Requested workload data were returned by PASBA (Appendix D). Report 1, Selected Sole Surgical Procedures, WBAMC, shows the number of patients and corresponding bed days for CY 1980 and 1981, for the 85 procedures studied. It should be noted that data provided shows only those procedures done alone and not in conjunction with another coded procedure. This was specified to insure that data would be captured only on patients whose procedures would be eligible for ambulatory surgery. The presence of other, more complicated procedures, done in conjunction with coded procedures studied would provide invalid data for demand forecasts.

Total number of patients and corresponding bed days for each of the coded procedures is itemized by service at Table 1. Due to the non-availability of data for December 1981, totals for the first eleven months of CY 81 were multiplied by a factor of 1.083 to provide expected totals for CY 81. This was based on the assumption that workload is relatively constant for each month. A study of monthly data shows no significant decrease for December 1980.

TABLE 1

WBAMC WORKLOAD OF SELECTED SOLE PROCEDURES

SERVICE	CY 1980 NO.	CY 1980 BED DAYS	JAN-NOV 1981 NO.	JAN-NOV 1981 BED DAYS	ADJUSTED CY 81 NO.	ADJUSTED CY 81 BED DAYS
Plastic Surgery	231	1300	207	1336	224	1447
ENT	83	270	72	258	78	280
Orthopaedics	180	847	117	753	127	816
Ophthalmology	146	571	120	435	130	471
OB/GYN	391	658	323	578	350	626
General Surgery	290	1446	233	1112	252	1205
Urology	22	100	16	74	17	80
Oral Surgery	55	273	50	401	54	434
TOTALS	1398	5465	1136	4947	1232	5359

In developing a demand forecast for ambulatory surgery, Kraft recommends that hospitals review all surgical procedures resulting in a length of stay of one to three days.[26] This information was requested from PASBA, and was provided in Reports 2b and 3b, which give workload data by frequency of occurrences (number of patients) for CY 1980 and 1981, respectively.

A study of data for both CYs in Report 1 shows that the vast majority of those coded procedures listed resulted in average LOS greater than three days. In CY 1980 for example, approximately 24 percent of those procedures showed an average LOS of three days or less, 40 percent showed four days or less, and 60 percent showed six days of less. It is not possible to pinpoint exact reasons for these longer LOS's for what are considered relatively minor procedures. The fact that WBAMC is a teaching facility is undoubtedly a large factor for the higher accumulation of bed days. The teaching environment simply requires a more structured approach to the practice of medicine, which in turn requires more time per patient. It is

postulated that in military hospitals with a teaching mission, workload studies for procedures resulting in a LOS of five days or less may render better information from which to develop a demand forecast.

In an effort to determine if the selected sole procedures listed in Report 1 constitute the majority of those most suitable for consideration for ambulatory surgery, a comparison was made of total number of patients undergoing those procedures with totals of all patients listed in Reports 2b and 3b. In CY 1980 the selected sole procedures studied accounted for 50.7 percent of all surgical patients with a LOS of three days or less. For CY 1981, 45.2 percent of the patients were attributed to these procedures.

All procedures listed on Report 3b were cross-referenced to Report 1 for CY 1981, to insure that no group of coded procedures that show high frequency was inadvertently eliminated from the study. Procedures with a frequency of 20 or more on Report 3b were noted. It was observed that a relatively large number of endoscopy procedures, many of which are done on an outpatient surgery basis at many civilian hospitals, were not considered. Most significant of these were Laparoscopies (Code 1694), which show a frequency of 57. Other procedures that had high frequencies were Special Radiologic Procedures, Computerized Tomography (CT) Scans, and Diagnostic Nuclear Medicine Studies, all of which would probably not be candidates for the proposed program. From this it is concluded that a majority of the more frequent procedures were identified. Although many of the less frequent procedures would also be eligible for this program, they were not studied further.

One error was noted in the coding of procedures submitted to PASBA. The Chief, Peripheral Vascular Surgery, recommended that angiographies be considered for ambulatory surgery. Only arteriographies of the thorax (Code 3329) were entered; therefore the returned data did not reflect other angiography procedures that should also be considered. Based on all angiographies listed on Reports 2b and 3b (Codes 3309 through 3349) a total of 68 occurrences were noted in CY 1980 and 99 for CY 1981. These figures will be used in the utilization forecast.

A review of the questionnaire responses revealed that an organized ambulatory surgery program would be considered very beneficial for WBAMC. Of the ten physicians questioned, nine felt that such a program would be beneficial, one was undecided. Eight physicians stated that their services would be frequent users, one was undecided, and one felt that the service would only be used occasionally due to type of surgery (neurosurgery) conducted. Six of the respondents stated they had experience with organized ambulatory surgery programs, and four stated they did not.

Various positive aspects of ambulatory surgery listed by responding physicians are as follows: (1) would provide for better bed utilization and conservation of resources; (2) would be a convenience to patients, patients would prefer returning home to familiar surroundings soon after surgery; (3) sense of well-being when convalescing at home; (4) parallels the state of the art in the private (civilian) sector; (5) would enhance the surgical training program.

Negative aspects cited by physicians included: (1) not applicable to certain active duty patients (i.e., single patients, or those living in a barracks); (2) there is a need to develop a better method of accountability to provide proper workload credit for such a program; (3) such a

program would require a change in scheduling and attitudes, i.e., smaller, shorter cases must be scheduled first to allow sufficient recovery time that same day.

Overall, the questionnaires revealed an overwhelmingly positive response favoring establishment of an organized program. The conclusion drawn is that the program would be frequently utilized by a majority of the surgical services for patients qualified to be entered into the program.

Following a detailed review of workload data on selected sole procedure studies and of overall predisposition of the surgical staff toward the program, a forecast of expected level of utilization was developed. These estimates are based on the assumption that only those procedures studied and listed in Report 1 would initially be included in the program. It is probable that as successes are noted, other procedures of less frequency would be included.

Consultation with the Chief, WBAMC Anesthesia Service and Operating Room, indicated that approximately 80 percent of all patients undergoing minor elective surgery are ASA Class I or II patients.[27] Considering the fact that not all Class I or II patients are eligible for the outpatient mode of surgery, it is further assumed that 70 percent of all patients undergoing the selected sole procedures studied would be eligible for this program.

Using the total number of patients listed on Table 1 and adding angiography patients not previously counted, 1,466 patients in CY 1980 and 1,331 in CY 1981 had one of the sole procedures listed. Using the 70 percent factor, 1,026 patients in CY 1980 and 932 in CY 1981 would have been considered eligible for ambulatory surgery. Based on these figures, it is

concluded that approximately 1,000 patients per year would initially be treated in the proposed program.

Patient Flow Through the Proposed System

The successful implementation of an integrated ambulatory surgery program is contingent upon establishment of a smooth and efficient patient flow through the system. Such a program will require the cooperation of a number of departments much the same as exists for treating inpatients. The major difference is that this program proposes to accomplish in a few hours those procedures presently being done in two or three inpatient days. Since the primary goal is efficiency, every effort must be made to eliminate system bottlenecks and insure expeditious flow patterns.

It is recommended that a separate ambulatory surgery nursing unit (ASNU) be established to provide coordination for the program, as well as required nursing and administrative support. Discussion of the proposed location and staffing will be presented later. With the exception of the ASNU, use of existing staff and facilities is recommended. Further, existing standing operating procedures will be used wherever possible to minimize confusion and inconvenience for both patients and staff.

Patients will be required to be seen on three separate days: (1) day of referral, (2) day of pre-anesthesia interview, and (3) day of surgery. Appendix E, The Proposed Ambulatory Surgery Procedural Guide, provides a detailed listing of individual tasks and responsibilities on each of these days. The following discussion is a general description of events for each day:

Day of Referral.--Figure 1 depicts proposed patient flow on the day of referral.

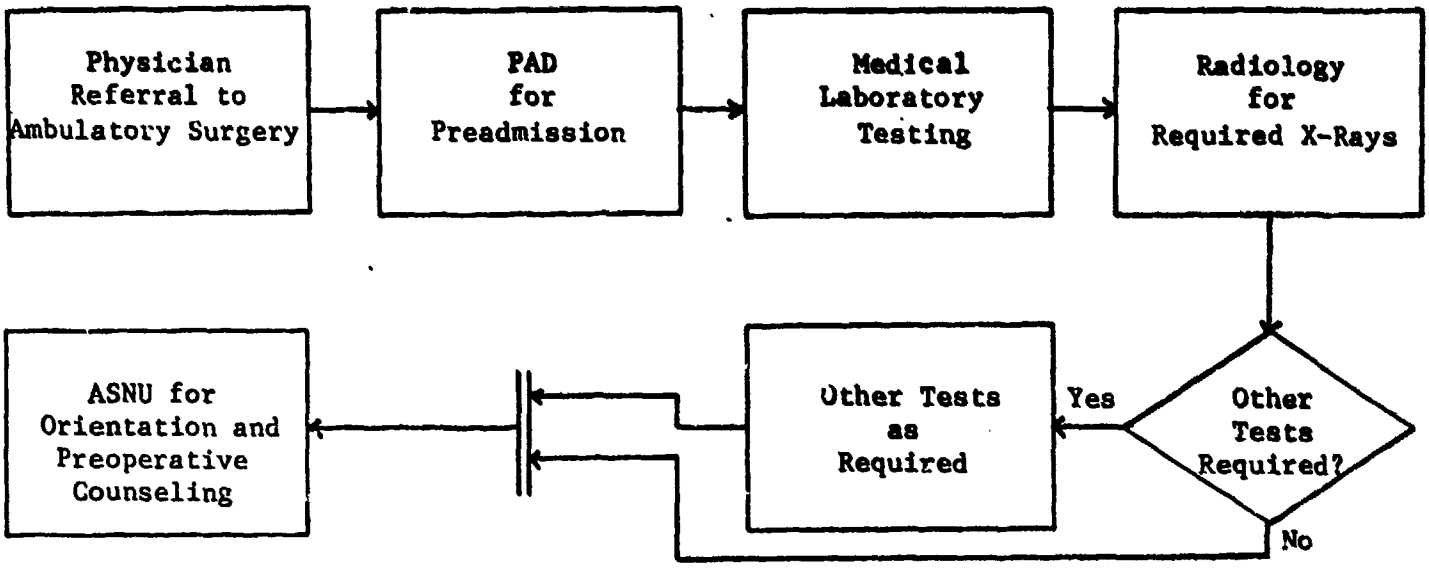

Figure 1. Day of Referral Activities

Patients will enter the program when the physician determines that the surgical procedure required can be done on an outpatient basis. It is important that a brief description of this concept be provided to the patient along with assurances that ambulatory surgery constitutes safe, state of the art medical practice. The patient should also receive a brief appraisal of additional responsibilities incurred by this mode of treatment. The advantages and conveniences of the system should also be addressed as deemed appropriate. A pre-admission physical examination should be conducted on the initial visit, and all required forms and medical-legal protocols should be completed at this time. Adequate instructions should be given regarding applicable day of referral activities.

A pre-admissions packet will be completed in the Admissions Office of the Patient Administration Division (PAD). Although these patients are actually treated on an "outpatient" basis, since they do not

remain overnight, they will actually occupy a hospital bed for a very brief period. Pre-operative laboratory, x-ray, or other diagnostic tests should also be done on this day, but could be postponed to another day if necessary. Sufficient time must be allowed for the processing, recording, and transmittal of results to the ASNU prior to the day of the pre-anesthesia interview.

The ASNU is the final area to be visited on this day. An orientation to the ASNU should be conducted, followed by a short but complete pre-operative teaching session designed to more adequately educate the patient regarding the program and his/her self-care responsibilities. It is recommended that a brochure be developed which provides information on those key teaching points discussed. Some information to be provided includes the following:

a. The patient must adhere to the rule that no food or fluids can be taken after midnight prior to the day of surgery.

b. If the patient feels confused or has unanswered questions, he/she should contact either the physician or the ASNU.

c. The patient must notify the physician of any change in physical condition prior to surgery, such as a cold or fever. Even minor ailments may require special consideration.

d. The patient should check with the physician before taking any medications prior to surgery. Medications prescribed by other physicians should be made known to the surgeon.

e. Patients should leave all jewelry and valuables at home. A military identification card and medical card will be needed.

f. Patients must arrange beforehand to have a responsible adult to drive them home following surgery. Patients must be cautioned against driving or important decision-making in the first 24 hours following surgery.[28]

The use of videotapes as teaching instruments has proven very effective in a number of existing programs. The patient will be given an appointment for a pre-anesthesia interview prior to departing the ASNU.

2. Day of Pre-anesthesia Interview.--The interview with the anesthesiologist of nurse anesthetist cannot take place until all pre-operative test results have been compiled. Thus, a separate hospital visit must be established to complete this important requirement. For patients who are to receive other than general anesthestics, necessary counseling and protocols can normally be conducted on the day of referral, but could be postponed until the day of surgery.

At the appointed time the patient will report to the ASNU where any pertinent pre-operative instructions are reiterated, to include the arrival hour on the day of surgery. The patient will be given necessary forms for the interview and asked to proceed to the Anesthesia Office. An anesthesiologist or nurse anesthetist will review the record, conduct the appropriate physical examination, and counsel the patient regarding the procedure.

3. Day of Surgery.--Figure 2 depicts patient flow through the system on this day.

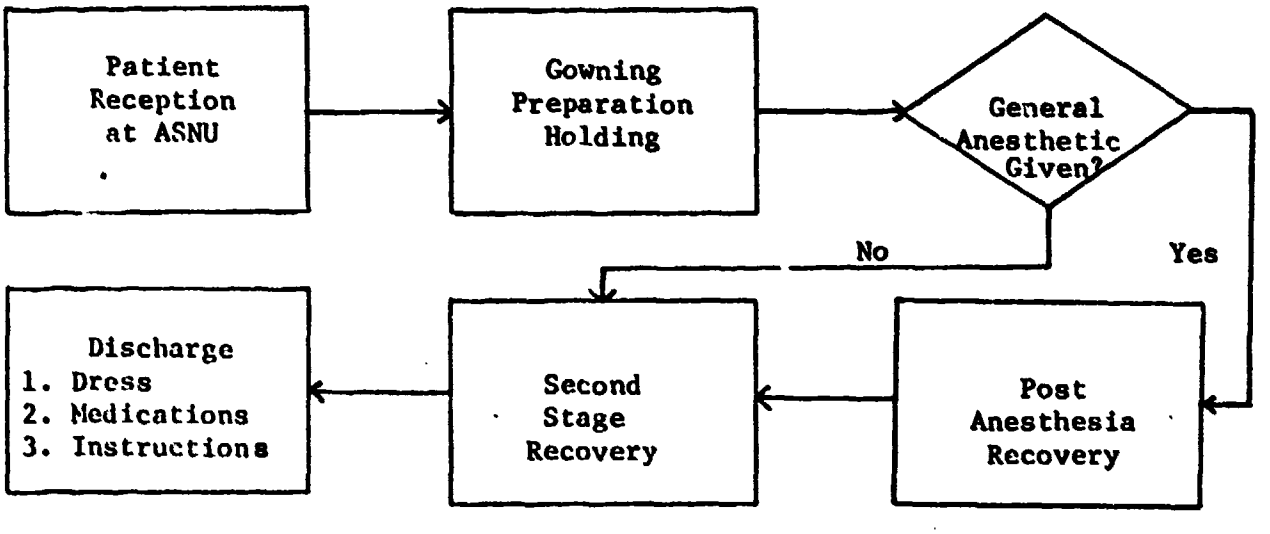

Figure 2. Day of Surgery Activities

Upon arrival, the ASNU Head Nurse, or designee, will affix the identification bracelet to the patient's wrist. The Ward Clerk will notify the Admissions Office of the admission. Following inprocessing, the patient will be escorted to the designated hospital room for gowning, where he will remain until transfer to the OR. Surgical preparation and transfer are the responsibilities of the OR staff.

If a general or regional anesthetic was administered, the patient will be transported to the Post Anesthesia Recovery Area (PAR), where he will remain until necessary recovery criteria are met with regards to activity, consciousness, color, ventilation, and circulation. General anesthetic patients will normally remain in the PAR a minimum of one hour.[29]

Upon return to the ASNU by recovery room personnel, the patient is returned to his designated bed for further recovery and observation. At the appropriate times the staff will encourage ambulating and taking of clear liquids. As appropriate, post-operative teaching should be conducted. Patients should be told what to do should complications develop following discharge. A brochure containing appropriate phone numbers should be provided.

The patient's family plays a very important supportive role both before and after surgery, and should be included in teaching, as appropriate. Since ambulatory surgery is an especially effective program for certain pediatric surgical cases, the nursing staff must anticipate the special needs and concerns of the parents and provide indicated teaching or counseling.

Prior to discharge, the attending physician must conduct a physical examination and complete the discharge note. In the event complications

develop at any time on this day, the physician will make necessary arrangements to have the patient transferred to one of the surgical wards.

Once dressed and cleared for discharge, the patient will be escorted in a wheelchair to the appropriate discharge area by an ASNU staff member. Accrued hospital charges may be paid at the Treasurer's Officer prior to departure, or a bill can be mailed to the home address. Additional coordination may be required if medications are to be picked up at the Outpatient Pharmacy.

It is highly recommended that on the day following surgery an ASNU staff member, preferably the Head Nurse, call the patient to insure that recovery is progressing normally. This followup has proven very beneficial in many civilian ambulatory surgery programs. A patient satisfaction survey should also be developed for use as a monitor for the program. Every effort should be made to insure that effective, action-oriented patient relations remain in effect. The program can succeed only if the delivery of caring, high quality patient care is perceived.

Establishment of an Ambulatory Surgery Nursing Unit

WBAMC has a serious shortage of floor space to facilitate the expanding mission of many departments. This is mainly due to the vast increases in medical technology which were not existent when the architectural plans of the hospital were developed in the 1960s. The overcrowded conditions existing in most areas of the hospital make it difficult to identify a suitable area to accommodate an ASNU that could realistically be made available.

Some clinics have small operating rooms and other areas that could be modified to house a freestanding ambulatory surgery area, but proposing the use of one of these is not considered feasible due to existing missions and workload. Further, until ambulatory surgery has proven itself to be effective, it is probable it will suffer a rather low priority for both space allocation and staffing.

Faced with these limited alternatives, a search was made of the nursing wards in the main hospital to identify a suitable area. A study was made of average monthly patient census on each ward to locate an area with low patient density. Ward 10 East, the Acute Respiratory Disease (ARD) and ambulatory patient care ward, was found to have the lowest density by a very large margin. This ward, with 22 operating beds and an expansion capability of over 60 beds, had an average occupancy of only 6.9 beds per day from April 1981 to December 1981, the only recent months for which figures were readily available. During this time the average monthly range was 3.7 to 10.5 occupied beds per day. Inspection of the ward revealed that adequate space is available to use for an ASNU; therefore, this area is recommended. Figure 3 is a floor plan of Ward 10 East.

To isolate the ASNU from other Ward 10E functions to the greatest extent possible, it is recommended that it be located in one of the eastern corners of the ward. Initially two four-bed rooms and two two-bed rooms are recommended and could be expanded as demand increases. This should provide sufficient space and allow for a varied mix of patients at any given time. Rooms T-15 through T-18, or rooms T-19 through T-22 are specifically recommended. One of the two doctors's offices, T-68 or T-69

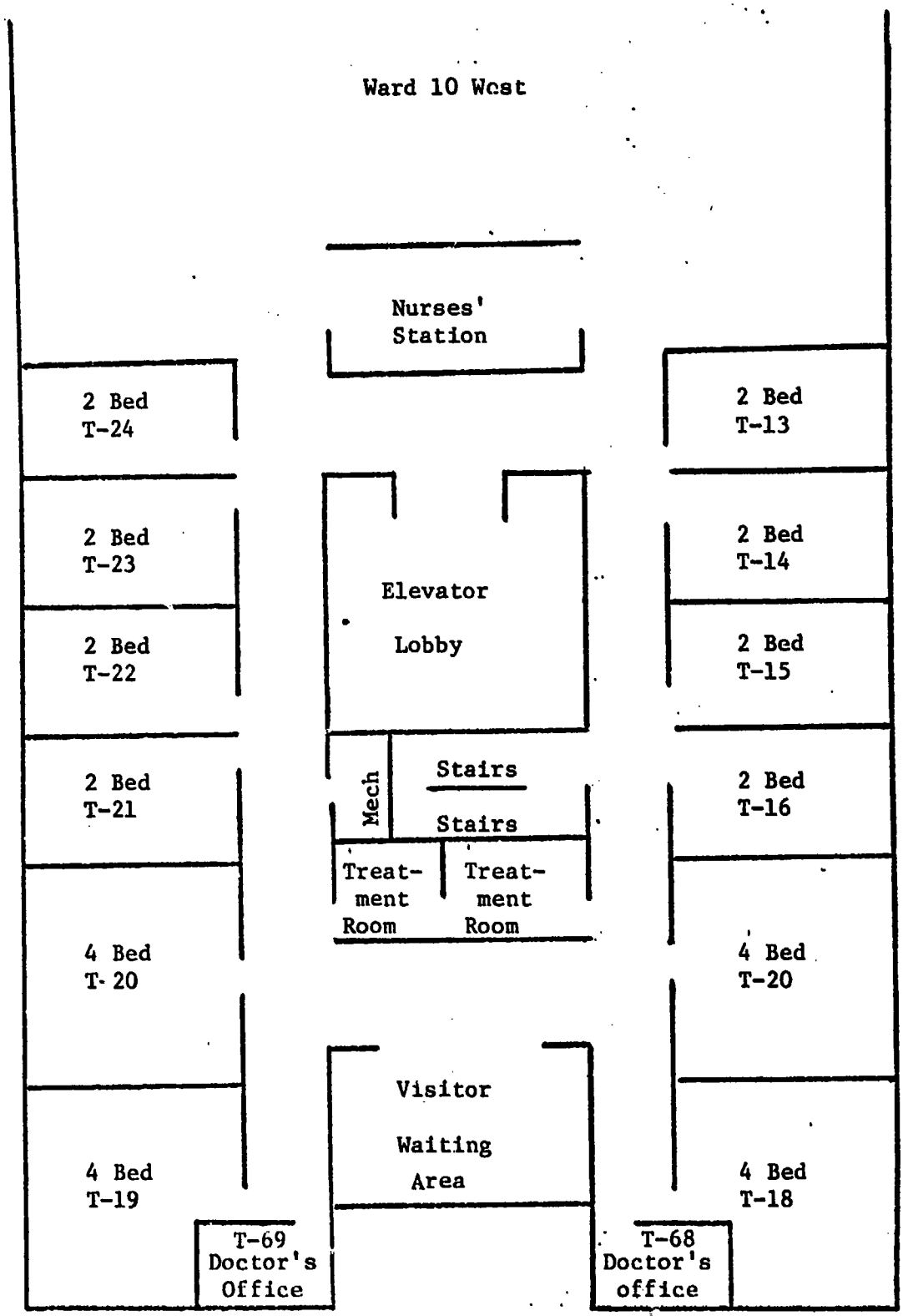

Figure 3. Ward 10 East Floor Plan

should also be made available for ASNU staff use. One advantage of locating in one of these areas is the close proximity of a large dayroom which can be used for a family waiting area.

Since the ward is not designed for the unique flow of ambulatory patients some compromises may be required. In assigning rooms, the ASNU Head Nurse must consider not only age and sex of the patient, but also scheduled time of surgery. It is not advisable to mix pre-operative and post-operative patients in the same area, although it may not be possible to completely separate these patients. Patients suffering any minor post-operative problems or complications should be provided a private room when available.

In the event ASNU beds are required for use in an ARD crisis or other urgent situation, the ambulatory surgery mission could be temporarily terminated and the staff could be utilized for other duties as needed.

Staffing the Ambulatory Surgery Nursing Unit

Ambulatory surgery represents a different mode of accomplishing an existing mission and does not require a new mission statement for implementation.[30] Staffing requirements to be presented are based only on workload projections forecast in this study. As the program evolves and new procedures are incorporated by the medical staff, total productivity will increase significantly. Because of the large number of less frequent procedures not studied which could be included, it is very possible that over 2000 patients per year may eventually be treated in this program. Consequently, staffing levels above those to be recommended here may later be required in the ASNU.

Local appraisal is the yardstick code which must be used since no known prototype of the proposed ASNU exists in a military setting. The work unit to be used for productivity management is the occupied bed day (OBD). The unit will remain operational from 0700 to 1630 on weekdays with surgery scheduled between 0800 and 1200.

The projected staff requirement of one registered nurse professional, two nurse assistants, and one ward clerk is recommended. The proposed Schedule X is at Appendix F. These requirements were made without reference to any possible personnel consolidations that may occur with the existing Ward 10E staff. This was done to present a clearer description of actual ASNU manpower requirements. Further, it seems appropriate to keep the ambulatory surgery mission separate from existing missions to the greatest extent possible because of its unique operational aspects.

The ASNU Head Nurse must be a registered professional nurse in order to adequately perform the wide range of nursing and supervisory requirements necessary in caring for patients with specialized and intense needs. Pre-operative nursing functions are concerned with assessment, planning, instruction, and physical and mental preparation. Postoperative nursing involves physical care, encouragement, postoperative teaching, and evaluation.[31]

In order to provide better continuity in the ASNU, the two nurse para-professionals should be civilian positions. Because of the teaching and psychological aspects of ambulatory surgery nursing care, special consideration must be given to selecting only those individuals with good communicative and other interpersonal skills for the three nursing positions.

The ASNU Ward Clerk plays an important role in the program. This individual is responsible for maintaining separate files for each patient. This requires gathering medical information from several different areas. The Ward Clerk must also coordinate scheduling with the referring clinics and perform duties as receptionist and clerical assistant.

Financial and Workload Projections

As noted in the Introduction, one of the greatest limitations of this study is the inability to precisely define the actual costs that could be saved in removing selected patients from hospital beds by implementing ambulatory surgery. Within the military's present accounting system, expenses are attributed to the various cost centers without regard to the amount of resources expended on any specific category of patients. To further complicate this dilemma, the relatively fixed costs such as Military Pay and Allowances (MPA) and Base Operation (BASOPS) expenses, which will not change with ambulatory surgery, are proportioned to each cost center through a form of step-down accounting used in the Uniform Chart of Accounts (UCA).

While the UCA does not lend itself well to precise cost isolation, the fact that various costs are itemized and credited to the different cost centers allows for development of some rather general financial projections. Since the UCA figures to be presented combine expenses of all categories of surgical patients, actual numbers should be used only to determine potentials for ambulatory surgery.

The UCA calculates cost per OBD for each service by summation of MPA, BASOPS, and Operation and Maintenance, Army (OMA) expenses credited

to a given service, divided by total accrued OBDs for that service. Using the assumption that 70 percent of patients receiving one of the selected sole procedures in CY 1981 would have been eligible for ambulatory surgery, Table 2 provides total expense that would have been attributed to these patients.

TABLE 2

COSTS PER OBD BY SERVICE

Service	Adjusted CY 81 OBDs	X	FY 81 Cost Per OBD	=	Total X	70%
Plastic Surgery	1447		$163.91		$237,178	$166,024
ENT	280		242.85		67,998	47,599
Orthopaedics	816		170.73		139,316	97,521
Ophthalmology	471		197.55		93,046	65,132
OB/GYN	623		259.59		162,503	113,752
General Surgery	1205		220.26		265,413	185,789
Urology	80		187.28		14,982	10,488
Oral Surgery	434		171.18		74,292	52,005
Peripheral Vascular Surgery	396		269.71		106,805	74,764
TOTALS	5755				$1,161,533	$813,074

Within the $813,074 figure calculated, it is necessary to identify those variable costs which are subject to change with ambulatory surgery. Specifically, nursing ward costs should be studied since clinic, OR, and Recovery Room costs will remain fairly level. The following variable cost activities were selected for study: supply costs, which include both medical and non-medical supplies (up to $200); linen costs; pharmacy costs; Department of Pathology (medical laboratory) costs; and ration costs.

Since the Departments of Obstetrics/Gynecology, Surgery, and Orthopaedics will be the only participants in ambulatory surgery, an examination of the above cost variables was conducted for nursing wards

caring for patients of the three departments. Intensive care areas were excluded from the study. FY 1981 UCA cost figures were used. Supply costs were reported in dollars, but linen, pharmacy, and pathology costs were reported in number of procedures, or weighted procedures. Dollar cost was calculated by determining the hospital-wide cost of one procedure multiplied by number of procedures attributed to different cost centers studied. The cost of rations was studied separately using the average cost per ration served for the FY. Table 3 provides results of this study. Note that surgery includes all services previously listed, other than Obstetrics/ Gynecology and Orthopaedics.

TABLE 3

VARIABLE COST ISOLATION BY DEPARTMENT

Dept	Supply Cost	Ration Cost (OBDx3.84)	Linen Cost (#ProcX.85)	Pharmacy Cost (#WtProcX9.64)	Pathology Cost (#WtProcX.81)	Total OBD	Cost/ OBD
OB/GYN	95617	55081	118190	577571	79146	14344	64.52
Surgery	189925	136965	184740	2565310	214233	35668	92.27
Ortho	65979	71274	103949	479416	50223	18561	41.53

Using figures from Table 3, and the demand forecast presented earlier, Table 4 shows total selected variable costs that would have been attributed to 70 percent of those patients receiving one of the selected sole procedures in CY 1981.

TABLE 4

VARIABLE COSTS FOR SELECTED SURGICAL PATIENTS

Department	Cost/OBD	Selected Procedure OBDs	Total Cost
Obstetrics/Gynecology	64.52	438	28260
Surgery	92.27	3019	278563
Orthopaedics	41.53	571	23714
			$330,537

Comparing the results of Table 2 and Table 4, it can be concluded that approximately 40 percent of total costs for those considered to be eligible for ambulatory surgery can be attributed to the variable costs studied. In the worst case estimate it is postulated that at least one-third of the $330,537 should be saved with ambulatory surgery.

Actual costs of conducting the proposed program must also be considered in the financial analysis. Since no construction or equipment costs are required, the only additional costs will be manpower and limited amounts of supplies and linens. Manpower costs based on one captain with six years in service and three GS-04, Step 5, civilians is approximately $64,000. Additional variable expenses of $15,000 for the ASNU would raise the annual cost to $79,000. The impact of lost revenue from payment of patient per diem rates was not calculated due to varying rates among beneficiaries, but is considered low. Total cost of conducting the proposed program should be approximately $110,000.

In formulating conclusions regarding the overall impact of ambulatory surgery on WBAMC, it is helpful to determine the probable impact on reported workload. To do this, total MCCUs that were actually generated by the selected sole procedure patients were compared with that which would have been reported using ambulatory surgery. In this study, each patient enrolled in the proposed program was considered to have generated 11 MCCUs (1 admission plus 1 OBD). The exact "with" ambulatory surgery formula is as follows:

Number of patients X 10 + (.7)(Number of patients) X 1 + (.3)(actual OBDs) X 1 = MCCUs with ambulatory surgery.

Table 5 provides the results of this study.

TABLE 5

COMPARISON OF MCCUs FOR CY 1981 DATA

Service	Number	OBDs	MCCUs Without Ambulatory Surgery	MCCUs With Ambulatory Surgery
Plastic Surgery	224	1477	3687	2839
ENT	78	280	1060	919
Orthopaedics	127	816	2086	1604
OB/GYN	350	626	4126	3933
General Surgery	252	1205	3725	3058
Urology	17	80	250	206
Oral Surgery	54	434	974	708
Peripheral Vascular	99	396	1386	1178
TOTALS			19065	15969

The loss of 3096 MCCUs would have been insignificant since this accounted for less than .5 percent of the total MCCUs reported for the year. This finding should alleviate the concerns of those who might oppose such a program on the grounds of lost workload credits.

Because the above financial and workload projections offer only general conclusions regarding the impact of ambulatory surgery at WBAMC, empirical studies are required to determine the exact benefits and cost savings. It can be stated, however, that implementation of the proposed program presents no apparent financial or workload risk, since in the worst case estimate the program would probably operate close to the break even point.

FOOTNOTES

[1]Randolph M. Grossman, "Is Ambulatory Surgery Less Expensive?" Hospitals, May 16, 1979, p. 112, 116.

[2]Ibid.

[3]Marilyn Baader, Vice President of Crouse-Irving Memorial Hospital in a presentation to the American Hospital Association Seminar titled: "Ambulatory Surgery: Implementing and Managing a Successful Hospital Program,' Minneapolis, MN, October 29, 1981.

[4]Grossman, p. 112.

[5]Peter F. Drucker, Managing in Turbulent Times, Harper and Row Publishers, New York, 1980, p. 14.

[6]George L. Hoffman, "Quality Control in Ambulatory Surgery," Bulletin of the American College of Surgeons, Vol 66, No. 1, November 1981, p. 6.

[7]Herbert E. Natof, "Complications Associated with Ambulatory Surgery," Journal of the American Medical Association, Vol 244, No. 10, September 5, 1980, pp. 1116-1118.

[8]"ACS Reports," Bulletin of the American College of Surgeons, Vol 66, No. 1, November, 1981.

[9]These standards were developed in part from the following source: Sharon M. Buske, "A Quality Assurance Program You Can Use," Successful Management of Ambulatory Surgery Programs, American Health Consultants, Atlanta, Georgia, 1981, pp. 309-363.

[10]Linda A. Burns and Mindy S. Ferber, "Ambulatory Surgery in the United States: Development and Prospects," The Journal of Ambulatory Care Management, Vol 4, No. 3, August 1981, p.2.

[11]Thomas P. O'Donovan, "The Pros and Cons of Ambulatory Surgery," Ambulatory Surgical Centers, Development and Management, Thomas R. O'Donovan ed., Germantown, MD: Aspen Systems Corp., 1976, p.12.

[12]Ibid.

[13]Marlene J. Berkoff, "Planning and Designing Ambulatory Surgery Facilities for Hospitals," The Journal of Ambulatory Care Management, Vol 4, No. 3, August, 1981, p.46.

[14]Interview with Colonel James W. Herman, Chief of the Operating Room Nurse Section, William Beaumont Army Medical Center, January 22, 1982.

[15]Ibid.

[16]Presentation given by Richard O. Kraft, Clinical Professor of Surgery, University of Michigan Medical Center, to the AHA Ambulatory Surgery Seminar, October 29, 1981.

[17]Samuel L. Lieberman, et al, "Hospital-Based Outpatient Surgery," New York State Journal of Medicine, Vol 75, No. 3, p.437.

[18]This list was compiled by the Day Surgery Unit of Glenn Falls Hospital, Glen Falls, New York.

[19]Thomas R. O'Donovan, p. xiv.

[20]Lieberman, et al, p. 438.

[21]M. Dennis Barton, "Outpatient Surgery and Anesthesia," Primary Care, Vol 4, No. 1, March 1977, p. 184.

[22]Telephone conversation with CPT Mark Lenneville, Ambulatory Surgery Unit Administrator, Walter Reed Army Medical Center, Washington, D.C., March 8, 1982.

[23]M. Dennis Barton, pp. 184-185.

[24]R.K Dieter Haussman, Principal, Health and Medical Division, Booz, Allen and Hamilton, in a presentation to the AHA Ambulatory Surgery Seminar, October 30, 1981.

[25]Ibid.

[26]Richard O. Kraft, AHA Ambulatory Surgery Seminar, October 29, 1981.

[27]Interview with MAJ Aron Elteto, Chief of Anesthesiology and Operating Room, William Beaumont Army Medical Center, El Paso, Texas, March 18, 1982.

[28]Patient responsibilities were developed from the following source: Douglas D. Hawthorne, "Management Forum: Patient Responsibilities," Same Day Surgery, May, 1979, pp. 56-57.

[29]Interview with LTC Ralph Earnest, Chief, Intensive Care Nursing Section, William Beaumont Army Medical Center, El Paso, Texas, January 27, 1982.

[30]LTC R. Alba, Chief, of Manpower/Survey Staffing Guides Branch, Force Development Division, Health Services Command, in a presentation given to the HSC Ambulatory Patient Care Conference, Fort Sam Houston, Texas, March 31, 1982.

[31] Susan Ann Cox, "Perioperative Nursing in the Ambulatory Setting," Point of View, Vol 18, No. 4, 1981 (Published by Ethicon, Inc.)

III. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Ambulatory surgery has been proven to be safe and efficient medical practice, and has greatly proliferated in the civilian health care industry in recent years. This study has shown this to be a viable concept for WBAMC. Such a program could be implemented with very little financial risk. Further, it has been shown that ambulatory surgery will result in no significant loss in productivity in terms of MCCU credits.

The major strengths of ambulatory surgery do not rest so much with the number of positions that could be decreased since no manpower reductions are forecast. Rather, the major incentive for implementation at WBAMC is the tremendous potential it presents to alleviate the multiple problems created by nurse staffing shortages. As beds are freed by ambulatory surgery, existing nursing staff will become available to care for other patients.

While the proposed ambulatory surgery model does not by itself create additional surgical capacity, it does free beds that could be filled if a greater surgical capacity is developed through scheduling and operational improvements in the main OR. With the surgical backlogs that exist in different areas, higher surgical productivity, coupled with ambulatory surgery could increase the total reported workload by a significant amount.

Ambulatory surgery is a concept whose time has come for WBAMC. The response from the questionnaires to the various service chiefs indicates that such a program would receive wide acceptance and support from the medical staff. Due to the presence of a wide range of surgical specialties and large overall workload, WBAMC would be an outstanding site to test this innovative form of medical practice in a military setting. The implementation of the Army's first integrated ambulatory surgery program at WBAMC would further provide a fine example for other military hospitals in the development of similar programs.

Recommendations

It is recommended that the WBAMC Commanding General approve implementation of the proposed program. The CPS should appoint an ambulatory surgery executive committee, tasked with the responsibility of developing necessary SOPs; delineating specific staff responsibilities; preparing an approved list of procedures which are to be done on an outpatient basis when the patient's condition permits; educating the staff regarding the program; and monitoring both utilization and quality of the program. Recommended committee members are:

1. Chief, Department of Surgery, Chairman
2. Chief, Department of Orthopaedics
3. Chief, Department of Obstetrics/Gynecology
4. Chief, Anesthesia Service
5. Head Nurse, ASNU
6. Administrator, CPS
7. Senior representatives from the following departments:

   Patient Administration Division
   Department of Radiology
   Department of Pathology

An effective ambulatory surgery program requires extensive coordination among a number of different departments. Responsible department heads must devote special emphasis towards insuring that sound management principles, particularly those of planning and control, are properly implemented. The recommended committee should meet frequently during the early stages of program development and implementation. As preliminary system problems are resolved, the committee may elect to meet less frequently. The on-going responsibility of this committee will then be one of providing direction to the program, resolving problems, and monitoring the overall quality of patient care provided. This committee should report directly to the WBAMC Medical Care Evaluation/Quality Assurance/Utilization Review/ Risk Management Committee on matters relating to quality assurance. Further, each participating department should incorporate ambulatory surgery into their existing Quality Assurance Programs.

In order to realize the full potential of ambulatory surgery, it is recommended that WBAMC conduct further studies designed to develop better scheduling and control procedures of the main OR facilities. Some specific areas recommended for study are the establishment of centralized scheduling, automation of OR scheduling, increased control of time allocated for procedures, and the development of policies for ambulatory surgery scheduling.

It is recommended that the Commanding General include ambulatory surgery in WBAMC's strategic planning process. As the program proves itself successful, additional resources should be considered to allow for needed expansion. When conditions permit, the implementation of a free-standing facility should be seriously considered from either existing or newly constructed floor space.

APPENDIX A

List of Procedures

DAY SURGERY PROCEDURES

ENT
Antrostomy
Antral Window
Arch Bars, Application, Removal
Biopsy Neck Mass
Caldwell Luc
Cautery, Epitaxis
Closed Reduction, Nose, Zygoma
Ear, Microscopic Examination
Ear, Removal Foreign Body
Eardrum Cyst, Removal
Esophageal Dilitation
Inclusion Cyst, Excision
Laryngoscopy
Laryngoscopy (With Operative Procedure)
Mouth Lesions, Biopsy, Excisions
Myringoplasty
Myringotomy (with or without Tubes)
Nasal Foreign Bodies, Removal
Nasal Fracture, Closed Reduction
Nasal Fracture, Open Reduction
Nasal Polypectomy
Nasopharynx (Exam under Anesthesia)
Otoscopy
Otoscopy (With Excisions, Foreign Body Removal)
Palate, Biopsy
Palate Repair (minor)
PE Tubes, Insertion, Removal
Removal Choanal Polyps
Rhinoplasty
Septal Reconstruction/Septoplasty SMR
Submaxillary Calculus, Removal
Thyroglossal Duct Cyst, Excision
Tongue, Biopsy, Excision Lesions
Wedge Ressection Lip
Wiring of Fractured Jaw

ENDOSCOPY
Bronchoscopy
Bronchoscopy (With Operative Procedure)
Colonoscopy
Colonoscopy (With Operative Procedure)
Esophagoscopy
Esophagoscopy (With Operative Procedure)
Esophagogastroduodenoscopy
Esophagogastroduodenoscopy (With Operative Procedure)
Laparoscopy
Laparoscopy (With Operative Procedure)
Laryngoscopy
Laryngoscopy (With Operative Procedure)
Procto-Sigmoidoscopy
Procto-Sigmoidoscopy (With Operative Procedure)
Cystoscopy
Cystoscopy (With Operative Procedure)
Arthroscopy
Arthroscopy (With Operative Procedure)

EYE
Cataract, Excision
Chalazion, Excision
Conjunctival Lesions, Excision
Cryopexy, Eye
Discission
Ectropian or Entropian Repair
Excision Lid Lesions
Eye Exam under Anesthesia
Eye Muscle Surgery (Bilateral)
Eye Muscle Surgery (Unilateral)
Iridectomy
Lacrimal Duct Probing
Pterygium, Excision
Repair of Lacerations
Removal Foreign Bodies, Eye
Suture, Removal

GENERAL SURGERY
Abcess, I & D
Anal Tag, Excision
Basal Cell Lesions, Excision
Brachial Cleft Cyst, Excision
Breast Biopsy (Bilateral)
Breast Biopsy (Unilateral)
Breast Implant Insertion and REmoval (Bilateral)
Breast Implant Insertion and Removal (Unilateral)
Cervical Nodes, Excision
Debridement of wounds
Epigastric Hernia Repair
Fistulectomy
Foreign Body Removal without X-Ray
Foreign Body Removal with X-Ray
Frenulectomy-Tongue
Ganglion, Excision
Gynecomasta, Male Mastectomy (Bilateral)
Gynecomasta, Male Mastectomy (Unilateral)
Hemangioma, Excision
Hemorrhoidectomy
Hydrocelectomy
Inguinal Herniorrhaphy (Infant Bilateral)
Inguinal Herniorrhaphy (Infant Unilateral)
Inguinal Herniorrhaphy (Adult Bilateral)
Inguinal Herniorrhaphy (Adult Unilateral)
Inguinal Exploration
Inguinal Nodes, Excision
Ingrown Toenails, Excision
Keratosis, Excision, Currettage
Lacerations, Repair, Revision of
Lipoma, Excision
Lysis of Adhesions
Masses, Excision of small to medium size and area
Melanoma, Excision
Muscle Biopsy
Orchiopexy
Pilonidal Cyst, Excision
Pedicle Graft, 2nd, 3rd Stage Repairs
Plantar Warts, Excision, Fulgeration, Laser Excision

GENERAL SURGERY (Continued)

Rectal Biopsy
Rectal Polypectomy
Rectal Dilitation
Removal Lesion with Skin Graft
Scalene Node Biopsy
Sebaceous cyst Excision
Secondary Wound Closure
Skin Graft
Skin Lesions, Excision
Stitch Granuloma, Excision
Stoma Revision
Suture Removal
Temporal Artery, Biopsy
Thyroglossal Duct Cyst, Excision
Umbilical Herniorrhaphy
Varicose Vein, Excision and Erasure
Vermilleonectomy(Upper or Lower)
(Both Lips)
Lip, Wedge Ressection

GYN

Bartholin Cyst, Excision, I & D
Cervical Cone
Cervical Dilitation
Cervical, Biopsy
Cervical, Polypectomy
Condylomata Accumulata, Laser Excision
Culdacentesis
Culdoscopy
D&C, Polypectomy
D&C
D&D, Conization
Episiotomy Repair of, Revision
Exam (GYN) under anesthesia
Hymenotomy
Hysterosalpingogram
IUD, Removal
Labial Lesion, Excision
Laparoscopy-Diagnostic
Laparoscopy, Bilateral Tubal Coagulation - Dilatation & currettage
Laparoscopy, Bilateral Tubal Coagulation Low Voltage
Laparoscopy, Bilateral Tubal Coagulation
Perinorrhaphy, Mini A/P Repair
Therapeutic Abortion - D&C Suction
Tubal Insufflation

GYN,Continued

Vaginal Stenosis, Revision
Vaginal Tumor, Excision
Vaginoplasty
Vulvar Lesions, Biopsy
Vulvar Warts, Excision, Fulgeration, Laser Exc.

NEUROSURGICAL

Carpal Tunnel Decompression
Mortons Neuroma, Excision
Neuroma, Excision
Scalp Lacerations, Repair
Scalp Wounds, Secondary Repair, I&D
Temporal Artery, Biopsy
Ulnar Nerve Transfer

ORAL

Extractions, Full Mouth
Extractions Partial
Impacted Teeth, Removal
Peridontal Surgery
Restorative Dentistry

ORTHOPEDIC

Amputation, Toes, Fingers
Amputation Revision, Arm, Leg
Amputation Revision, Toes, Fingers
Arthrodesis
Arthroplasty
Arthroscopy- Diagnostic
Arthroscopy, Operative
Arthrotomy
Arthrotomy with Arthroscopy
Bone Graft - Toes, Fingers
Bunionectomy - Bilateral
Bunionectomy - Unilateral
Bursae, Excision
Carpal Tunnel Decompression
Cast Change With Manipulation
Cast Change - Arm, Leg
Closed Reduction Fracture with X-Ray
Closed Reduction Fracture without X-Ray
Exostosis - Excision
Fingernail, Toenail, Excision
Foreign Body Removal
Ganglion - Excision
Hammertoes/Tenatomies/Ressection of Bones
Hand Surgery - Traumatic Repair
Hand Surgery Reconstructive
Hardware, Removal
Manipulation Joints with X-Ray
Manipulation Joints without X-Ray

ORTHOPEDIC Continued

Metatarsal Head, Excision Bilateral
Metatarsal Head Excision Unilateral
Morton's Neuroma
Nerve Repair - with Microscope
Nerve Repair - without Microscope
Neuroma
Open Reduction Fracture - with X-Ray - toes, fingers
Open Reduction Fracture - without X-Ray - toes, fingers
Olecranon Bursa, Excision
Osteotomy
Phalangectomy
Plantar Wart, Excision, Fulgeration, Laser Excision
Prosthesis Replacement - Toe
Shoulder, frozen - Manipulation, Injection
Signovectomy
Tendon,Repair
Tendon Sheath, Release
Tenosynovectomy
Trigger finger, Release
Unlar Nerve Transfer
Z-plasty

PLASTIC

Augmentation Mammoplasty (Bilateral)
Augmentation Mammoplasty (Unilateral)
Augmentation Mammoplasty with Reconstruction Bilateral
Augmentation Mammoplasty with Reconstruction Unilateral
Blepharoplasty - Upper and Lower
Blepheroplasty - Upper and Lower
Chin Prosthesis - Insertion/Removal
Dermabrasion
Flap, Revision
Keloid, Excision
Lipectomy
Otoplasty, Bilateral
Otoplasty, Unilateral
Reduction Mammoplasty
Removal/Exchange - Breast Implants Bilateral
Removal/Exchange - Breast Implants Unilateral
Rhinoplasty
Rhydidectomy
Scar Revision - Single Multiple
Septoplasty- Nasal Septal Reconstruction/SMR
Skin Graft - Full Thickness
Skin Graft - Split Thickness
Skin Lesions, Excision
Suture Removal
Vermilionectomy
Wedge Resection Lip
Z-Plasty - large, face etc
Z-plasty - small- finger etc

UROLOGICAL

Circumcision - Adult
Circumcision - Pediatric
Cystoscopy
Cystoscopy with operative procedure
Cystometrogram
Cystometrogram with cystoscopy
Fulgeration Penile Warts
Hydrocelectomy
Meatotomy
Prostate Biopsy
Testicular Biopsy
Uretheral Dilatation
Vasectomy

SPECIAL CHARGES

Electroshock Therapy
Nerve Blocks - Intercostal
Nerve Blocks - Lumbar Sympathetic
Nerve Blocks - Stellate

APPENDIX B

Physician Questionnaire (Blank)

AMBULATORY SURGERY QUESTIONNAIRE

(Please Type or Print Responses)

1. The following procedures are those most commonly performed by my department/service at WBAMC. (Please feel free to include procedures not listed on the attached sheet).

SURGICAL PROCEDURES	APPROXIMATE MONTHLY CASELOAD
a.	
b.	
c.	
d.	
e.	
f.	
g.	
h.	

Please list at least the top four most common procedures. List more if these procedures represent a significant portion of your overall caseload.

2. Do you have experience with an organized ambulatory surgery program?

_____Yes _____No

3. If your response to question 2 was yes, please list those aspects of ambulatory surgery which you consider to be positive or negative.

Positive aspects:

Negative aspects:

4. Should WBAMC offer an organized ambulatory surgery program for your patients, what do you feel would be the level of utilization of such services by yourself and your staff?

_____Frequently _____Occasionally

_____Rarely _____Never

Comments:

5. Overall do you feel that an organized ambulatory surgery program would be beneficial?

_____Yes _____No

Comments:

6. If you desire to make any additional comments which would benefit this study, please make them below.

APPENDIX C

Request to Patient Administration Systems and Biostatistics Agency (PASBA)

DEPARTMENT OF THE ARMY
WILLIAM BEAUMONT ARMY MEDICAL CENTER
EL PASO, TEXAS 79920

HSHN-MEC

18 January 1982

SUBJECT: Request for Surgical Workload Data

Commander
Patient Administration Systems
and Biostatistics Agency
ATTN: HSHI-QBS (Terri Beam)
Fort Sam Houston, Texas 78234

1. As a part of my academic requirements for the US Army/Baylor University Program in Health Care Administration I am conducting a study to determine the feasibility of implementing a formal Ambulatory Surgery Program at William Beaumont Army Medical Center (WBAMC). In order to forecast the demand for such a program it is necessary to determine WBAMC's past workload for various surgical procedures.

2. Listed at Inclosure 1 are the ICDA-9 coded procedures for which I request data. I would like the total number of cases, plus bed days, on a monthly basis from January 1980, to the most current month for which data are available. I would also like to have a column giving the total number of cases and bed days for each surgical procedure. Inclosure 2 is a recommended format, which may be varied to accommodate your computer programs.

3. Please note that I do not desire data to be reported on surgical procedures that were performed in conjunction with other procedures, unless this is specifically indicated at Inclosure 1.

4. From a telephone conversation with Mrs. Graves, I understand that you may be able to retrieve data for WBAMC surgical cases that resulted in a hospital stay of 1-3 days. Such data would be very valuable to this study. I request such data in any format you can provide, but preferably on a monthly basis by ICDA code. A format such at that at Inclosure 2 would be the most acceptable.

5. Once you have reviewed this request, please call me at Autovon 979-2401/2450/2203 with any questions. Address the completed project as follows:

Headquarters
William Beaumont Army Medical Center
ATTN: Administrative Resident (MAJ Koehler)
El Paso, Texas 79920

HSHM-MZC

18 January 1982

SUBJECT: Request for Surgical Workload Data

6. I certainly appreciate your valuable service.

Harold C. Koehler

HAROLD C. KOEHLER
Major, MSC
Administrative Resident

2 Incl
as

REQUESTED PROCEDURES

PLASTIC SURGERY

CODE	SURGICAL PROCEDURES
5-875 5-874 5-873	Breast Surgery (Reduction, augmentation, reconstruction, etc)
5-090 5-096	Eyelid surgery (bleph., tarsal folds, ptosis)
5-217	Surgery of nose (Rhino., septorhino, fractures)
5-900	Facial cosmetic surgery (Rhytido., chem peel, etc.)
5-901	Abdominoplasty
6-898 5-275	Cleft lips and palate
5-891 5-893	Scar revisions (Including skin grafts and flaps)

ENT

5-203 5-194 thru 5-195	Mastoidectomy and Tympanoplasty
5-281 5-282	Tonsillectomy and/or adenoidectomy
5-217	Septal reconstruction/Septoplasty SMR
5-200	Myringotomy (with or without tubes)
5-221 5-222	Sinus Surgery (Antral Window, Caldwell-Luc)
5-191	Stapedectomy

Incl

ORTHOPAEDICS

5-782	Bunionectomies
5-813 5-819	Small joint arthoplasties
5-043	Carpal tunnel release
5-822 5-802 5-040 5-051	Ganglion excision
5-788	Hardware removal
8-837 5-824- 5-827	Extension tendon repair
1-697	Arthroscopy

OPHTHALMOLOGY

5-144 5-145 5-146	Cataract extraction
5-100- 5-109	Muscle
5-125	Penetrating keratoplasty
5-096	Blepharoplasty
1-831	Probing of nasolacrimal system in children

OBSTETRICS/GYNECOLOGY

5-663	Laparoscopic or mini lap sterilization
5-690	D & C (Therapeutic-Diagnostic)
5-753	Genetic Amniocentesis
5-671	Cervical Conization
3-918	Laser Therapy of Vulva, CX, and vagina
5-690	Suction D&C for incomplete abortion

GENERAL SURGERY

5-530	Inguinal Herniorrhaphy (Adult unilateral)			
5-511	Cholecystectomy			
5-530	Pediatric herniorrhaphy			
5-066	Thyroglossal duct cyst			
5-883-	Excisions			
5-712	5-242	5-112	5-261	8-186
5-909	5-860	5-612	5-641	
5-243	5-884	5-712	5-181	
5-091	5-631			

UROLOGY

6-652	Cystosopies (Ped) (Op procedure)
1-563	Prostatic biopsies
5-585	Urethral dilations
5-981 5-636	Vasectomies

ORAL SURGERY

5-230 5-231	Removal of teeth
5-246 8-389	Application and removal of arch bars
5-784 5-785	Minor osteotomies
1-545 5-273	Biopsy or excision of lesions

PERIPHERAL VASCULAR SURGERY

3-329	Angiography

APPENDIX D

Workload Data
(Includes Report 1, 2b and 3b)

Explanatory Notes:

1. Reports are as follows:

   a. Selected sole surgical procedures (Report 1) with pages a and b, Jan - Jun and Jul - Dec* and yearly total, respectively.

   b. All surgeries with 1 to 3 days length of stay -

      Report 2a - 3 digit codes for 1980
      Report 2b - 4 digit codes for 1980
      Report 3a - 3 digit codes for 1981
      Report 3b - 4 digit codes for 1981

2. Surgical codes used are those published in the International Classification of Procedures in Medicine (ICPM).

3. Report excludes carded for record only (CRO) cases.

4. Data exclude surgical procedures that were performed in another hospital or another facility, not a hospital.

* 5. Data for December 1981 are not available at this time.

SOURCE: Individual Patient Data System (IPDS) (RCS MED-345)

PREPARED BY:
Department of the Army
US Army Patient Administration Systems
and Biostatistics Activity
HSHI-QBS 11 FEB 1982

Report 1

Selected Sole Surgical Procedures, WBAMC, Jan - Dec 80

	Jan		Feb		Mar		Apr		May		Jun	
	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days
5875-Other repair and plastic operation on breast	-	-	-	-	-	-	3	31	1	4	2	20
5874-Reduction mammoplasty	2	17	2	12	-	-	1	3	3	14	5	32
5873-Augmentation mammoplasty	1	3	2	4	-	-	2	3	1	2	1	2
5090-Incision of eyelid	-	-	-	-	1	2	-	-	-	-	-	-
5096-Other repair of eyelids	4	11	3	6	5	12	3	7	3	10	3	9
5217-Repair and plastic operations on nose	4	26	10	40	10	42	6	30	5	22	6	32
5900-Facial rhytidectomy	-	-	2	9	1	4	-	-	3	15	1	18
5901-Size reduction plastic operation	-	-	1	16	-	-	1	7	1	2	1	14
5898-Plastic operations on lip & external mouth	1	1	-	-	-	-	1	4	1	3	-	-
5275-Palatoplasty	1	9	-	-	1	4	-	-	-	-	-	-
5891-Relaxation of scar or contracture of skin	1	7	2	17	-	-	-	-	3	13	2	12
5893-Other free skin grafts	-	-	2	7	-	-	-	-	1	67	-	-
5203-Mastoidectomy	-	-	-	-	-	-	-	-	-	-	-	-
5194-Myringoplasty	-	-	-	-	2	6	-	-	1	2	1	2
5195-Other tympanoplasty	2	6	-	-	-	-	-	-	-	-	-	-
5281-Tonsillectomy (w/o adenoidectomy)	2	8	7	28	5	19	2	10	3	19	2	6
5282-Tonsillectomy with adenoidectomy	1	1	1	3	-	-	-	-	-	-	-	-
5285-Adenoidectomy (w/o tonsillectomy)	-	-	-	-	-	-	1	2	-	-	2	11
5200-Myringotomy	2	2	3	4	-	-	4	4	-	-	-	-
5221-Intranasal antrotomy	-	-	-	-	-	-	-	-	-	-	-	-
5222-External maxillary antrotomy	-	-	-	-	1	4	-	-	2	10	-	-
5191-Stapedectomy	1	4	-	-	-	-	-	-	-	-	-	-
5782-Ostectomy for hallux valgus	2	5	2	6	1	7	4	27	3	8	-	-
5813-Arthroplasty of foot and toe	1	2	1	8	1	2	-	-	1	4	-	-
5819-Other repair of joint structure	-	-	-	-	-	-	-	-	-	-	-	-
5043-Freeing of adhesions & decompression of nerve	5	10	3	7	6	14	10	33	5	12	2	16
5822-Excision of lesion of muscle, tendon & fascia of hand	4	8	2	4	2	4	-	-	2	4	2	4
5802-Excision or destruction of lesion of joint	1	2	-	-	-	-	-	-	-	-	-	-

* * See Notes at End of Report * *

Report 1

Selected Sole Surgical Procedures, WBAMC, Jan - Dec 80

	Jul		Aug		Sep		Oct		Nov		Dec		Total	
	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days
5875-Other repair and plastic operation on breast	-	-	4	27	-	-	1	3	2	11	-	-	13	96
5874-Reduction mammoplasty	1	4	-	-	3	26	2	27	2	8	1	3	22	146
5873-Augmentation mammoplasty	4	17	5	21	3	12	2	4	1	3	-	-	22	71
5090-Incision of eyelid	-	-	-	-	1	3	-	-	-	-	-	-	2	5
5096-Other repair of eyelids	2	5	4	8	2	4	3	6	2	4	2	5	36	87
5217-Repair and plastic operations on nose	6	40	9	51	7	39	6	24	6	44	5	22	80	412
5900-Facial rhytidectomy	-	-	-	-	2	10	4	18	1	5	1	4	15	83
5901-Size reduction plastic operation	2	19	2	23	-	-	1	9	1	18	-	-	10	106
5898-Plastic operations on lip & external mouth	-	-	2	22	-	-	-	-	-	-	2	8	7	38
5275-Palatoplasty	1	8	-	-	-	-	1	16	-	-	-	-	4	37
5891-Relaxation of scar or contracture of skin	2	8	-	-	-	-	-	-	-	-	1	5	11	62
5893-Other free skin grafts	-	-	3	46	1	18	1	1	1	16	-	-	9	155
5203-Mastoidectomy	-	-	-	-	-	-	-	-	-	-	1	11	1	11
5194-Myringoplasty	2	6	1	4	-	-	2	4	-	-	1	2	10	26
5195-Other tympanoplasty	-	-	2	9	-	-	-	-	-	-	-	-	4	15
5281-Tonsillectomy (w/o adenoidectomy)	1	4	2	8	6	23	3	12	2	6	-	-	35	143
5282-Tonsillectomy with adenoidectomy	-	-	1	2	-	-	1	2	2	4	-	-	6	12
5285-Adenoidectomy (w/o tonsillectomy)	-	-	-	-	-	-	-	-	-	-	2	4	5	17
5200-Myringotomy	2	6	2	2	1	1	2	2	3	3	3	4	22	28
5221-Intranasal antrotomy	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5222-External maxillary antrotomy	-	-	-	-	-	-	-	-	-	-	-	-	3	14
5191-Stapedectomy	-	-	-	-	-	-	-	-	-	-	-	-	1	4
5782-Ostectomy for hallux valgus	-	-	-	-	2	9	2	10	1	13	-	-	17	85
5813-Arthroplasty of foot and toe	-	-	1	4	-	-	-	-	-	-	-	-	5	20
5819-Other repair of joint structure	-	-	-	-	-	-	-	-	1	39	-	-	1	39
5043-Freeing of adhesions & decompression of nerve	4	10	5	11	3	6	5	14	3	9	5	10	66	152
5822-Excision of lesion of muscle, tendon & fascia of hand	2	4	-	-	-	-	-	-	1	2	-	-	15	30
5802-Excision or destruction of lesion of joint	-	-	-	-	-	-	-	-	-	-	-	-	1	2

* * See Notes at End of Report * *

Report 1

Selected Sole Surgical Procedures, WBAMC, Jan - Dec 80

	Jan		Feb		Mar		Apr		May		Jun	
	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days
5040-Division and excision of nerve	-	-	-	-	-	-	-	-	-	-	-	-
5051-Sympathectomy	-	-	-	-	-	-	-	-	-	-	1	4
5788-Removal of internal fixation appliance	4	14	3	70	4	18	3	13	4	14	2	11
5837-Other plastic operations on muscle, tendon and fascia	-	-	1	2	-	-	-	-	-	-	-	-
5824-Suture of muscle, tendon & fascia of hand	-	-	1	5	2	4	-	-	2	10	1	4
5825-Transplantation of muscle and tendon of hand	-	-	-	-	-	-	-	-	-	-	-	-
5826-Reconstruction of thumb	-	-	-	-	-	-	-	-	-	-	-	-
5827-Plastic operation on hand with graft or implant	-	-	-	-	-	-	-	-	-	-	2	39
1697-Arthroscopy	5	36	2	13	4	16	4	24	3	24	2	23
5144-Intracapsular extraction of lens	6	20	15	56	10	54	9	60	6	24	6	21
5145-Extracapsular extraction of lens	-	-	-	-	3	22	-	-	-	-	2	10
5146-Other cataract extraction	-	-	1	4	-	-	1	5	2	8	-	-
5100-Myotomy and tenotomy of ocular muscles	-	-	-	-	-	-	-	-	-	-	-	-
5101-Excision of ocular muscle or tendon	2	4	2	5	1	4	4	8	-	-	2	4
5102-Advancement or recession of ocular muscle	1	2	-	-	1	4	4	8	1	2	2	4
5103-Transposition of ocular muscle	-	-	-	-	-	-	-	-	-	-	-	-
5104-Other shortening of ocular muscle	-	-	-	-	-	-	-	-	-	-	-	-
5105-Freeing of adhesions of ocular muscle	-	-	-	-	-	-	-	-	-	-	-	-
5109-Other operations on ocular muscle	-	-	-	-	-	-	-	-	-	-	-	-
5125-Corneal transplant	-	-	-	-	-	-	-	-	-	-	-	-
1831-Probing of nasolacrimal duct	-	-	-	-	-	-	-	-	-	-	2	2
5663-Bilateral endoscopic destruction or occlusion of fallopian tubes	4	8	11	26	11	25	13	28	8	16	6	12
5690-Dilation and curettage (of uterus)	19	26	12	13	15	28	22	28	22	31	24	27
5753-Amniocentesis	-	-	1	1	1	1	5	9	5	14	4	17
5671-Conization of cervix	-	-	-	-	-	-	1	2	-	-	-	-
3918-Other application of laser beam	-	-	-	-	-	-	-	-	-	-	-	-

* * See Notes at End of Report * *

Report 1

Selected Sole Surgical Procedures, WBAMC, Jan - Dec 80

	Jul		Aug		Sep		Oct		Nov		Dec		Total	
	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days
5040-Division and excision of nerve	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5051-Sympathectomy	-	-	-	-	-	-	1	3	-	-	-	-	2	7
5788-Removal of internal fixation appliance	2	7	3	52	3	8	-	-	1	4	-	-	29	211
5837-Other plastic operations on muscle, tendon and fascia	1	2	-	-	-	-	-	-	-	-	-	-	2	4
5824-Suture of muscle, tendon & fascia of hand	-	-	-	-	-	-	1	2	1	3	-	-	8	28
5825-Transplantation of muscle and tendon of hand	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5826-Reconstruction of thumb	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5827-Plastic operation on hand with graft or implant	-	-	-	-	-	-	1	25	-	-	1	5	4	69
1697-Arthroscopy	2	26	5	24	1	4	1	6	1	4	-	-	30	200
5144-Intracapsular extraction of lens	5	33	4	11	2	6	7	28	2	11	8	38	80	362
5145-Extracapsular extraction of lens	-	-	-	-	1	4	2	9	1	5	1	7	10	57
5146-Other cataract extraction	1	8	1	3	-	-	-	-	-	-	1	5	7	33
5100-Myotomy and tenotomy of ocular muscles	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5101-Excision of ocular muscle or tendon	1	2	-	-	2	13	-	-	2	4	3	7	19	51
5102-Advancement or recession of ocular muscle	2	4	2	4	4	13	2	4	3	7	5	10	27	62
5103-Transposition of ocular muscle	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5104-Other shortening of ocular muscle	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5105-Freeing of adhesions of ocular muscle	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5109-Other operations on ocular muscle	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5125-Corneal transplant	-	-	-	-	1	4	-	-	-	-	-	-	1	4
1831-Probing of nasolacrimal duct	-	-	-	-	-	-	-	-	-	-	-	-	2	2
5663-Bilateral endoscopic destruction or occlusion of fallopian tubes	17	38	16	35	21	44	11	26	14	34	3	6	135	298
5690-Dilation and curettage (of uterus)	15	19	15	18	11	17	26	30	14	22	25	33	220	292
5753-Amniocentesis	2	7	5	5	1	1	4	4	3	3	4	4	35	66
5671-Conization of cervix	-	-	-	-	-	-	-	-	-	-	-	-	1	2
3918-Other application of laser beam	-	-	-	-	-	-	-	-	-	-	-	-	-	-

* * See Notes at End of Report * *

Report 1

Selected Sole Surgical Procedures, WBAMC, Jan - Dec 80

	Jan		Feb		Mar		Apr		May		Jun	
	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days
5530-Repair of inguinofemoral hernia	14	58	14	46	15	80	16	76	16	74	9	44
5066-Excision of thyroglossal tract	-	-	2	7	-	-	-	-	-	-	-	-
5883-Surgical toilet of wound or infected tissue	1	3	4	15	2	9	4	28	5	28	2	32
5712-Other local excision or destruction of vulva and perineum	-	-	1	4	-	-	-	-	-	-	-	-
5909-Other operations	-	-	-	-	-	-	-	-	-	-	-	-
5243-Excision of dental lesion of jaw	-	-	-	-	-	-	-	-	-	-	-	-
5091-Excision or destruction of eyelid	-	-	-	-	-	-	-	-	2	6	-	-
5242-Other operations on gum	-	-	-	-	-	-	-	-	-	-	-	-
5860-Local excision of lesion of breast	-	-	-	-	1	2	-	-	-	-	1	1
5884-Local excision or destruction of skin and subcutaneous tissue	5	25	5	10	12	45	5	25	3	24	6	21
5631-Excision of cyst of epididymis	1	7	-	-	-	-	-	-	-	-	-	-
5112-Excision of lesion of conjunctiva	-	-	-	-	-	-	-	-	-	-	-	-
5612-Excision or destruction of scrotal lesion	-	-	-	-	-	-	1	8	-	-	-	-
5261-Excision of lesion of salivary gland	-	-	-	-	-	-	-	-	1	5	-	-
5641-Local excision or destruction of penis	-	-	-	-	-	-	-	-	-	-	-	-
5181-Excision or destruction of lesion of external ear	-	-	-	-	-	-	-	-	-	-	-	-
8186-Removal of nail	1	2	-	-	-	-	1	15	-	-	1	3
1652-Cystoscopy	2	6	2	8	1	5	1	2	1	3	2	17
1563-Prostate	-	-	-	-	-	-	1	1	1	9	-	-
5585-Dilation of urethra	-	-	-	-	-	-	-	-	-	-	-	-
5981-Surgical operations to produce male sterilization	-	-	-	-	-	-	-	-	-	-	-	-
5636-Vasectomy	-	-	-	-	-	-	-	-	-	-	-	-
5230-Forceps extraction of tooth	-	-	2	59	2	162	1	27	-	-	-	-
5231-Surgical removal of tooth	-	-	1	3	-	-	-	-	1	8	-	-
5246-Application of orthodontic appliance	-	-	-	-	-	-	-	-	-	-	-	-
8389-Removal of other fixation	-	-	-	-	-	-	-	-	-	-	-	-
5784-Partial ostectomy	1	11	3	27	1	20	3	11	3	13	2	11

* * See Notes at End of Report * *

Report 1

Selected Sole Surgical Diagnosis, WBAMC, Jan - Dec 80

	Jul		Aug		Sep		Oct		Nov		Dec		Total	
	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days
5530-Repair of inguinofemoral hernia	12	63	22	111	15	86	14	96	11	53	15	71	173	858
5066-Excision of thyroglossal tract	-	-	-	-	-	-	1	4	-	-	3	13	6	24
5883-Surgical toilet of wound or infected tissue	4	11	4	15	2	6	6	8	2	17	1	13	37	185
5712-Other local excision or destruction of vulva and perineum	-	-	-	-	1	2	-	-	-	-	1	2	3	8
5909-Other operations	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5243-Excision of dental lesion of jaw	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5091-Excision or destruction of eyelid	1	2	-	-	-	-	1	1	-	-	-	-	4	9
5242-Other operations on gum	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5860-Local excision of lesion of breast	-	-	1	5	-	-	-	-	-	-	-	-	3	8
5884-Local excision or destruction of skin and subcutaneous tissue	7	21	4	9	7	51	6	35	2	2	2	5	64	283
5631-Excision of cyst of epididymis	-	-	-	-	1	7	-	-	1	7	-	-	3	21
5112-Excision of lesion of conjunctiva	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5612-Excision or destruction of scrotal lesion	-	-	-	-	-	-	-	-	-	-	-	-	1	8
5261-Excision of lesion of salivary gland	-	-	-	-	-	-	-	-	-	-	1	7	2	12
5641-Local excision or destruction of penis	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5181-Excision or destruction of lesion of external ear	-	-	-	-	-	-	1	1	-	-	-	-	1	1
8186-Removal of nail	-	-	2	6	3	3	-	-	-	-	-	-	8	29
1652-Cystoscopy	3	28	-	-	2	5	2	9	-	-	2	3	18	86
1563-Prostate	-	-	-	-	1	3	-	-	-	-	1	1	4	14
5585-Dilation of urethra	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5981-Surgical operations to produce male sterilization	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5636-Vasectomy	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5230-Forceps extraction of tooth	-	-	1	5	1	6	1	1	-	-	2	8	10	268
5231-Surgical removal of tooth	2	6	2	7	5	16	3	7	-	-	1	3	15	50
5246-Application of orthodontic appliance	-	-	-	-	1	1	-	-	-	-	-	-	1	1
8389-Removal of other fixation	-	-	-	-	2	17	-	-	-	-	-	-	2	17
5784-Partial ostectomy	1	6	4	38	2	8	3	20	1	3	3	20	27	188

* * See Notes at End of Report * *

Report 1

Selected Sole Surgical Procedures, WBAMC, Jan - Dec 80

	Jan		Feb		Mar		Apr		May		Jun	
	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days
5785-Total ostectomy	-	-	-	-	-	-	-	-	1	2	-	-
1545-Surgical biopsy, mouth, other	-	-	-	-	-	-	-	-	-	-	-	-
5273-Excision of other parts of the mouth	-	-	-	-	-	-	-	-	-	-	-	-
3329-Other arteriography (angiography) of thorax	-	-	-	-	1	6	-	-	1	3	1	7

* * See Notes at End of Report * *

Report 1

Selected Sole Surgical Procedures, WBAMC, Jan - Dec 80

	Jul		Aug		Sep		Oct		Nov		Dec		Total	
	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days
5785-Total ostectomy	-	-	-	-	-	-	1	6	-	-	-	-	2	8
1545-Surgical biopsy, mouth, other	-	-	2	9	-	-	-	-	-	-	-	-	2	9
5273-Excision of other parts of the mouth	-	-	-	-	-	-	-	-	-	-	-	-	-	-
3329-Other arteriography (angiography) of thorax	-	-	1	2	1	3	-	-	1	2	1	2	7	25

* * See Notes at End of Report * *

Report 1

Selected Sole Surgical Procedures, WBAMC, Jan - Nov 81

	Jan		Feb		Mar		Apr		May		Jun	
	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days
5875-Other repair and plastic operation on breast	2	24	3	39	2	23	1	12	-	-	1	2
5874-Reduction mammoplasty	2	8	1	12	1	4	3	52	3	17	1	4
5873-Augmentation mammoplasty	4	16	2	10	2	9	1	2	-	-	-	-
5090-Incision of eyelid	-	-	-	-	-	-	-	-	-	-	-	-
5096-Other repair of eyelids	4	9	1	2	3	15	8	23	5	17	3	7
5217-Repair and plastic operations on nose	8	43	4	14	3	11	2	6	4	15	5	22
5900-Facial rhytidectomy	-	-	1	3	2	9	1	5	1	3	1	11
5901-Size reduction plastic operation	-	-	1	14	1	11	1	10	2	16	1	9
5898-Plastic operations on lip & external mouth	1	8	-	-	-	-	-	-	-	-	2	11
5275-Palatoplasty	-	-	-	-	1	7	-	-	-	-	-	-
5891-Relaxation of scar or contracture of skin	-	-	-	-	2	17	2	25	-	-	1	3
5893-Other free skin grafts	-	-	1	16	3	68	2	50	2	61	-	-
5203-Mastoidectomy	-	-	-	-	-	-	-	-	-	-	-	-
5194-Myringoplasty	-	-	1	4	1	2	2	4	1	2	1	3
5195-Other tympanoplasty	-	-	-	-	1	2	1	2	-	-	-	-
5281-Tonsillectomy (w/o adenoidectomy)	1	2	4	28	5	29	1	6	1	4	4	11
5282-Tonsillectomy with adenoidectomy	1	2	-	-	-	-	-	-	2	4	-	-
5285-Adenoidectomy (w/o tonsillectomy)	-	-	-	-	-	-	-	-	-	-	-	-
5200-Myringotomy	3	3	2	2	2	2	2	2	1	4	2	2
5221-Intranasal antrotomy	-	-	-	-	-	-	-	-	-	-	-	-
5222-External maxillary antrotomy	-	-	1	3	-	-	1	4	1	14	-	-
5191-Stapedectomy	1	3	3	12	-	-	-	-	1	2	-	-
5782-Ostectomy for hallux valgus	1	6	-	-	1	4	1	6	3	18	2	10
5813-Arthroplasty of foot and toe	-	-	-	-	-	-	2	9	-	-	-	-
5819-Other repair of joint structure	-	-	-	-	-	-	2	32	-	-	-	-
5043-Freeing of adhesions & decompression of nerve	4	13	1	3	8	35	3	15	2	9	2	19
5822-Excision of lesion of muscle, tendon & fascia of hand	-	-	1	2	2	6	-	-	2	7	-	-
5802-Excision or destruction of lesion of joint	-	-	-	-	-	-	-	-	-	-	-	-

* * See Notes at End of Report * *

Report 1

Selected Sole Surgical Procedures, WRAMC, Jan - Nov 81

	Jul		Aug		Sep		Oct		Nov		Total	
	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days
5875-Other repair and plastic operation on breast	5	19	2	13	3	25	3	28	-	-	22	185
5874-Reduction mammoplasty	3	12	2	8	2	14	1	3	-	-	19	134
5873-Augmentation mammoplasty	2	5	6	16	3	6	2	12	-	-	22	76
5090-Incision of eyelid	-	-	-	-	-	-	-	-	-	-	-	-
5096-Other repair of eyelids	7	24	3	8	4	26	5	30	-	-	43	161
5217-Repair and plastic operations on nose	3	7	4	32	4	39	13	87	-	-	50	276
5900-Facial rhytidectomy	1	6	2	9	4	23	1	9	-	-	14	78
5901-Size reduction plastic operation	2	12	1	12	3	21	-	-	-	-	12	105
5898-Plastic operations on lip & external mouth	-	-	-	-	-	-	-	-	-	-	3	19
5275-Palatoplasty	-	-	1	11	-	-	1	7	-	-	3	25
5891-Relaxation of scar or contracture of skin	-	-	-	-	3	11	2	20	-	-	10	76
5893-Other free skin grafts	-	-	1	6	-	-	-	-	-	-	9	201
5203-Mastoidectomy	-	-	-	-	2	9	-	-	-	-	2	9
5194-Myringoplasty	1	2	2	6	3	19	-	-	-	-	12	42
5195-Other tympanoplasty	-	-	-	-	-	-	-	-	-	-	2	4
5281-Tonsillectomy (w/o adenoidectomy)	-	-	5	20	5	17	4	21	-	-	30	138
5282-Tonsillectomy with adenoidectomy	-	-	-	-	-	-	1	3	-	-	4	9
5285-Adenoidectomy (w/o tonsillectomy)	-	-	-	-	-	-	1	2	-	-	1	2
5200-Myringotomy	-	-	-	-	-	-	1	1	-	-	13	16
5721-Intranasal antrotomy	-	-	-	-	-	-	-	-	-	-	-	-
5222-External maxillary antrotomy	-	-	-	-	-	-	-	-	-	-	3	21
5191-Stapedectomy	-	-	-	-	-	-	-	-	-	-	5	17
5782-Ostectomy for hallux valgus	2	7	3	13	1	4	2	7	-	-	16	75
5813-Arthroplasty of foot and toe	-	-	-	-	-	-	2	9	-	-	4	18
5819-Other repair of joint structure	1	16	-	-	1	2	-	-	-	-	4	50
5043-Freeing of adhesions & decompression of nerve	2	28	2	9	1	2	-	-	-	-	25	133
5822-Excision of lesion of muscle, tendon & fascia of hand	3	13	-	-	2	4	-	-	-	-	10	32
5802-Excision or destruction of lesion of joint	1	8	-	-	-	-	1	3	-	-	2	11

* * See Notes at End of Report * *

Report 1

Selected Sole Surgical Procedures, WBAMC, Jan - Nov 81

	Jan		Feb		Mar		Apr		May		Jun	
	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days
5040-Division and excision of nerve	-	-	-	-	-	-	-	-	-	-	-	-
5051-Sympathectomy	-	-	-	-	-	-	-	-	1	10	-	-
5788-Removal of internal fixation appliance	2	10	5	45	-	-	3	10	4	34	3	16
5837-Other plastic operations on muscle, tendon and fascia	2	4	-	-	-	-	-	-	-	-	-	-
5824-Suture of muscle, tendon & fascia of hand	1	1	-	-	1	2	1	5	-	-	1	2
5825-Transplantation of muscle and tendon of hand	-	-	1	8	-	-	-	-	-	-	-	-
5826-Reconstruction of thumb	-	-	-	-	-	-	-	-	-	-	-	-
5827-Plastic operation on hand with graft or implant	-	-	-	-	-	-	-	-	-	-	-	-
1697-Arthroscopy	-	-	1	6	1	13	-	-	1	7	2	18
5144-Intracapsular extraction of lens	3	9	5	21	5	24	1	3	4	19	-	-
5145-Extracapsular extraction of lens	1	5	-	-	2	7	3	27	-	-	1	4
5146-Other cataract extraction	-	-	-	-	4	20	-	-	-	-	1	7
5100-Myotomy and tenotomy of ocular muscles	-	-	-	-	-	-	-	-	-	-	-	-
5101-Excision of ocular muscle or tendon	6	23	-	-	1	5	2	4	-	-	1	2
5102-Advancement or recession of ocular muscle	-	-	4	17	4	13	6	15	1	2	2	4
5103-Transposition of ocular muscle	-	-	-	-	-	-	-	-	-	-	-	-
5104-Other shortening of ocular muscle	-	-	-	-	-	-	1	2	-	-	-	-
5105-Freeing of adhesions of ocular muscle	-	-	-	-	-	-	-	-	-	-	-	-
5109-Other operations on ocular muscle	-	-	-	-	-	-	-	-	1	1	-	-
5125-Corneal transplant	-	-	-	-	-	-	-	-	-	-	1	5
1831-Probing of nasolacrimal duct	1	1	-	-	4	4	2	2	2	2	4	4
5663-Bilateral endoscopic destruction or occlusion of fallopian tubes	8	18	13	31	9	21	13	28	11	27	14	24
5690-Dilation and curettage (of uterus)	14	21	12	20	21	36	18	29	16	31	21	36
5753-Amniocentesis	-	-	-	-	2	2	3	11	3	3	5	5
5671-Conization of cervix	-	-	-	-	-	-	-	-	-	-	-	-
3918-Other application of laser beam	-	-	-	-	-	-	-	-	-	-	-	-

** See Notes at End of Report **

Report 1

Selected Sole Surgical Procedures, WBAMC, Jan - Nov 81

	Jul		Aug		Sep		Oct		Nov		Total	
	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days
5040-Division and excision of nerve	-	-	-	-	-	-	-	-	-	-	-	-
5051-Sympathectomy	-	-	-	-	-	-	-	-	-	-	1	10
5788-Removal of internal fixation appliance	2	7	9	46	4	28	1	7	-	-	33	203
5837-Other plastic operations on muscle, tendon and fascia	-	-	-	-	-	-	-	-	-	-	2	4
5824-Suture of muscle, tendon & fascia of hand	2	36	1	6	-	-	-	-	-	-	7	52
5825-Transplantation of muscle and tendon of hand	-	-	-	-	-	-	-	-	-	-	1	8
5826-Reconstruction of thumb	-	-	-	-	-	-	-	-	-	-	-	-
5827-Plastic operation on hand with graft or implant	-	-	-	-	1	2	-	-	-	-	1	2
1697-Arthroscopy	1	17	3	24	1	52	1	18	-	-	11	155
5144-Intracapsular extraction of lens	2	14	5	32	5	22	1	4	-	-	31	148
5145-Extracapsular extraction of lens	3	10	1	9	1	3	1	6	-	-	13	71
5146-Other cataract extraction	-	-	-	-	-	-	-	-	-	-	5	27
5100-Myotomy and tenotomy of ocular muscles	-	-	-	-	-	-	-	-	-	-	-	-
5101-Excision of ocular muscle or tendon	3	7	-	-	2	4	2	9	-	-	17	54
5102-Advancement or recession of ocular muscle	6	14	3	15	3	6	5	14	-	-	34	100
5103-Transposition of ocular muscle	-	-	-	-	-	-	-	-	-	-	-	-
5104-Other shortening of ocular muscle	-	-	-	-	-	-	-	-	-	-	1	2
5105-Freeing of adhesions of ocular muscle	-	-	-	-	-	-	-	-	-	-	-	-
5109-Other operations on ocular muscle	-	-	-	-	-	-	-	-	-	-	1	1
5125-Corneal transplant	-	-	1	10	-	-	-	-	-	-	2	15
1831-Probing of nasolacrimal duct	1	1	-	-	-	-	2	3	-	-	16	17
5663-Bilateral endoscopic destruction or occlusion of fallopian tubes	16	24	15	31	19	40	13	26	1	4	132	274
5690-Dilation and curettage (of uterus)	18	23	15	27	13	25	16	17	2	3	166	268
5753-Amniocentesis	2	2	6	6	2	2	1	1	-	-	24	32
5671-Conization of cervix	-	-	-	-	-	-	-	-	1	4	1	4
3918-Other application of laser beam	-	-	-	-	-	-	-	-	-	-	-	-

** See Notes at End of Report **

Report 1

Selected Sole Surgical Procedures, WBAMC, Jan - Nov 81

	Jan		Feb		Mar		Apr		May		Jun	
	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days
5530-Repair of inguinofemoral hernia	9	64	14	74	12	65	15	53	17	77	12	48
5066-Excision of thyroglossal tract	-	-	1	3	1	3	-	-	-	-	-	-
5883-Surgical toilet of wound or infected tissue	1	16	2	11	3	6	5	47	7	26	3	21
5712-Other local excision or destruction of vulva and perineum	-	-	-	-	1	3	-	-	-	-	-	-
5909-Other operations	-	-	1	3	-	-	-	-	-	-	-	-
5243-Excision of dental lesion of jaw	-	-	-	-	-	-	-	-	1	2	-	-
5091-Excision or destruction of eyelid	-	-	-	-	1	9	-	-	-	-	2	14
5242-Other operations on gum	-	-	-	-	-	-	-	-	-	-	-	-
5860-Local excision of lesion of breast	1	3	-	-	1	2	1	5	-	-	-	-
5884-Local excision or destruction of skin and subcutaneous tissue	3	16	2	33	1	3	2	5	9	37	3	8
5631-Excision of cyst of epididymis	1	4	-	-	-	-	-	-	-	-	-	-
5112-Excision of lesion of conjunctiva	-	-	-	-	-	-	-	-	-	-	-	-
5612-Excision or destruction of scrotal lesion	-	-	-	-	-	-	-	-	-	-	-	-
5261-Excision of lesion of salivary gland	-	-	-	-	-	-	-	-	1	3	-	-
5641-Local excision or destruction of penis	-	-	-	-	-	-	-	-	-	-	-	-
5181-Excision or destruction of lesion of external ear	1	7	-	-	1	3	-	-	1	3	-	-
8186-Removal of nail	-	-	-	-	-	-	-	-	-	-	-	-
1652-Cystoscopy	1	3	1	6	1	10	1	1	1	4	2	7
1563-Prostate	-	-	-	-	-	-	-	-	2	5	-	-
5585-Dilation of urethra	-	-	-	-	-	-	-	-	-	-	1	2
5981-Surgical operations to produce male sterilization	-	-	-	-	-	-	-	-	-	-	-	-
5636-Vasectomy	-	-	-	-	-	-	-	-	-	-	-	-
5230-Forceps extraction of tooth	2	23	-	-	1	2	3	37	-	-	-	-
5231-Surgical removal of tooth	4	13	4	10	6	20	1	2	1	1	-	-
5246-Application of orthodontic appliance	-	-	-	-	-	-	-	-	-	-	-	-
8389-Removal of other fixation	-	-	-	-	-	-	-	-	-	-	-	-
5784-Partial ostectomy	3	25	1	4	4	28	6	37	2	17	5	56

* * See Notes at End of Report * *

Report 1

Selected Sole Surgical Procedures, WBAMC, Jan - Nov 81

	Jul		Aug		Sep		Oct		Nov		Total	
	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days
5530-Repair of inguinofemoral hernia	10	32	18	83	16	79	12	57	2	8	137	640
5066-Excision of thyroglossal tract	1	1	-	-	1	3	-	-	-	-	4	10
5883-Surgical toilet of wound or infected tissue	6	26	7	17	2	7	2	28	-	-	38	205
5712-Other local excision or destruction of vulva and perineum	-	-	-	-	-	-	-	-	-	-	1	3
5909-Other operations	-	-	-	-	-	-	-	-	-	-	1	3
5243-Excision of dental lesion of jaw	-	-	-	-	-	-	-	-	-	-	1	2
5091-Excision or destruction of eyelid	-	-	1	19	-	-	-	-	-	-	4	42
5242-Other operations on gum	1	1	-	-	-	-	-	-	-	-	1	1
5860-Local excision of lesion of breast	-	-	-	-	-	-	1	7	-	-	4	17
5884-Local excision or destruction of skin and subcutaneous tissue	4	13	5	22	5	19	-	-	-	-	34	156
5631-Excision of cyst of epididymis	-	-	1	6	-	-	-	-	-	-	2	10
5112-Excision of lesion of conjunctiva	-	-	-	-	-	-	1	5	-	-	1	5
5612-Excision or destruction of scrotal lesion	-	-	-	-	-	-	-	-	-	-	-	-
5261-Excision of lesion of salivary gland	-	-	-	-	-	-	-	-	-	-	1	3
5641-Local excision or destruction of penis	-	-	-	-	-	-	-	-	-	-	-	-
5181-Excision or destruction of lesion of external ear	-	-	-	-	1	2	-	-	-	-	4	15
8186-Removal of nail	-	-	-	-	-	-	-	-	-	-	-	-
1652-Cystoscopy	-	-	1	3	1	3	2	7	-	-	11	44
1563-Prostate	-	-	1	8	-	-	-	-	-	-	3	13
5585-Dilation of urethra	-	-	1	9	-	-	-	-	-	-	2	11
5981-Surgical operations to produce male sterilization	-	-	-	-	-	-	-	-	-	-	-	-
5636-Vasectomy	-	-	-	-	-	-	1	6	-	-	1	6
5230-Forceps extraction of tooth	-	-	-	-	-	-	-	-	-	-	6	62
5231-Surgical removal of tooth	4	40	3	4	5	12	6	11	-	-	34	113
5246-Application of orthodontic appliance	-	-	-	-	-	-	-	-	-	-	-	-
8389-Removal of other fixation	-	-	-	-	-	-	-	-	-	-	-	-
5784-Partial ostectomy	1	7	1	13	1	4	2	17	-	-	26	208

* * See Notes at End of Report * *

Report 1

Selected Sole Surgical Procedures, WBAMC, Jan - Nov 81

	Jan		Feb		Mar		Apr		May		Jun	
	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days
5785-Total ostectomy	-	-	-	-	1	4	-	-	-	-	1	4
1545-Surgical biopsy, mouth, other	-	-	-	-	-	-	-	-	-	-	-	-
5273-Excision of other parts of the mouth	-	-	-	-	-	-	1	4	-	-	-	-
3329-Other arteriography (angiography) of thorax	-	-	-	-	-	-	-	-	-	-	-	-

* * See Notes at End of Report * *

Report 1

Selected Sole Surgical Procedures, WBAMC, Jan - Nov 81

	Jul		Aug		Sep		Oct		Nov		Total	
	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days	No	Bed Days
5785-Total ostectomy	-	-	-	-	-	-	1	6	-	-	3	14
1545-Surgical biopsy, mouth, other	-	-	-	-	-	-	-	-	-	-	-	-
5273-Excision of other parts of the mouth	-	-	-	-	-	-	-	-	-	-	1	4
3329-Other arteriography (angiography) of thorax	1	13	-	-	-	-	-	-	-	-	1	13

Footnotes:

1. Surgical code 5981 (Surgical Operations to Produce Male Sterilization) was not used by the Army after June 1980.
2. Days used were bed days this MTF.
3. Dash (-) indicates zero frequency.
4. Procedures applicable to more than one of the requested groups appear only in the first reporting group.

SOURCE: Individual Patient Data System (IPDS) (RCS MED-345)

PREPARED BY:
Department of the Army
US Army Patient Administration Systems
and Biostatistics Activity
HSHI-QBS
11 FEB 1982

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PAGE 1 SURGICAL PROCEDURES WITH 1 TO 3 DAYS LENGTH OF STAY PROGRAM ID S349

WILLIAM BEAUMONT ARMY MEDICAL CENTER

CY 80

	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
1	1272	CENTRAL VENOUS PRESSURE MEASURE	23
2	1273	INTRAVENOUS CATHETERIZATION, HEART	35
3	1275	RETROGRADE CATHETERIZATION OF LEFT HEART	16
4	1278	OTHER CATHETERIZATION OF HEART	1
5	1334	OTHER CYSTOMETRY	2
6	1358	INTERNAL CLINICAL GYN EXAMINATION	3
7	1363	ELECTROMYOGRAPHY	3
8	1402	PERCUTANEOUS BIOPSY OF NERVE	1
9	1428	BIOPSY OF LARYNX BY LARYNGOSCOPY	4
10	1425	BONE MARROW BIOPSY	2
11	1426	LYMPHATIC BIOPSY	1
12	1432	BIOPSY OF BRONCHUS BY ENDOSCOPY	1
13	1440	BIOPSY ESOPHAGUS BY ENDOSCOPY	12
14	1441	BIOPSY OF STOMACH BY ENDOSCOPY	12
15	1450	BIOPSY OF COLON BY ENDOSCOPY	26
16	1451	BIOPSY OF SIGMOID COLON BY ENDOSCOPY	1
17	1453	BIOPSY OF ANUS AND PERIANAL REGION	1
18	1454	LIVER PERCUTANEOUS BIOPSY	29

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PAGE 2 SURGICAL PROCEDURES WITH 1 TO 3 DAYS LENGTH OF STAY PROGRAM ID S349

WILLIAM BEAUMONT ARMY MEDICAL CENTER

CY 80

	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
19	1460	PERCUTANEOUS BIOPSY OF KIDNEY	3
20	1463	BIOPSY OF PROSTATE	9
21	1471	ENDOMETRIAL BIOPSY	2
22	1473	ENDOCERVICL BIOPSY	1
23	1475	OTHER,UNSPECIFIED CERVICAL BIOPSY	40
24	1482	BREAST BIOPSY	1
25	1484	BONE OR JOINT BIOPSY	1
26	1500	SURGICAL BIOPSY OF SKIN, SUBCUTANEOUS TISSUE	2
27	1501	SURGICAL BIOPSY OF BREAST	1
28	1502	SURGICAL BIOPSY OF MUSCLE	1
29	1503	SURGICAL BIOPSY OF BONE	4
30	1504	SURGICAL BIOPSY OF JOINT	1
31	1540	SURGICL BIOPSY,LIP	2
32	1544	SURGICAL BIOPSY OF PALATE, UVULA	1
33	1545	SURGICAL BIOPSY OF MOUTH, OTHER PARTS	1
34	1551	SURGICAL BIOPSY OF LIVER	1
35	1556	SURGICAL BIOPSY OF COLON	3
36	1557	SURGICAL BIOPSY OF RECTUM	2

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WILLIAM BEAUMONT ARMY MEDICAL CENTER

CY 80

	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
37	1563	SURGICAL BIOPSY OF PROSTATE	2
38	1565	SURGICAL BIOPSY OF TESTIS	1
39	1571	SURGICAL BIOPSY OF CERVIX	8
40	1572	SURGICAL BIOPSY OF VAGINA	1
41	1573	SURGICAL BIOPSY OF VULVA	2
42	1586	SURGICAL BIOPSY OF SUPERFICIAL LYMPH NODE	3
43	1620	BRONCHOSCOPY	1
44	1630	ESOPHAGOSCOPY	7
45	1632	ESOPHAGOGASTROSCOPY	3
46	1633	GASTROSCOPY	8
47	1636	DUODENOSCOPY	3
48	1640	INTESTINAL ENDOSCOPY VIA EXISTING STOMA	1
49	1641	COLONOSCOPY	51
50	1642	SIGMOIDOSCOPY	2
51	1643	PROCTOSCOPY	22
52	1650	URETEROSCOPY	1
53	1652	CYSTOSCOPY	26
54	1655	URETHROSCOPY	1
55	1660	HYSTEROSCOPY	1
56	1663	COLPOSCOPY	12

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WILLIAM BEAUMONT ARMY MEDICAL CENTER
CY 88

	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
57	1679	OTHER SPECIFIED ENDOSCOPY	99
58	1689	ENDOSCOPY NOS	4
59	1694	LAPAROSCOPY	51
60	1695	OPERATIVE ENTEROSCOPY OR OTHER ABDOMINAL ENDOSCOPY	1
61	1697	ARTHROSCOPY	9
62	1724	EXERCISE TOLERANCE TESTS	23
63	1729	CARDIAC FUNCTION TESTS NOS	3
64	1838	PROBING OF LACRIMAL PASSAGES	7
65	1831	PROBING OF NASOLACRIMAL DUCT	2
66	1842	PERICARDIOCENTESIS DIAGNOSTIC	2
67	1843	BRONCHIAL ASPIRATION	1
68	1846	ASPIRATION OF KIDNEY OR PELVIS	2
69	1854	DIAGNOSTIC JOINT ASPIRATION	1
70	3211	MYELOGRAPHY	28
71	3251	INTRAVENOUS UROGRAPHY	68
72	3253	RETROGRADE UROGRAPHY	5
73	3257	CYSTOGRAPHY	5
74	3263	PERCUTANEOUS CHOLANGIOGRAPHY	2

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PAGE 6 SURGICAL PROCEDURES WITH 1 TO 3 DAYS LENGTH OF STAY PROGRAM ID S349
WILLIAM BEAUMONT ARMY MEDICAL CENTER
CY 88

	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
93	3713	ORTHOVOLTAGE RADIATION	2
94	3759	RADIOISOTOPIC TELERADIOTHERAPY	1
95	3829	IMPLANTATION OR INSERTION OF RADIC ACTIVE SOURCES	1
96	3839	INJECTION OR INSTILLAION OF RADIOISOTOPES	2
97	3899	OTHER RADIOTHERA-PEUTIC AND NUCLEAR MEDICINE PROCEDURE	4
98	5011	CRANIOTOMY	1
99	5036	SPINAL DRAINAGE	1
100	5042	SUTURE OF NERVE	3
101	5043	FREEING ADHESIONS, DECOMPRESS NERVE	47
102	5045	NERVE TRANSPOSITON	6
103	5047	INJECTION INTO NERVE	4
104	5059	OTHER OPERATIONS ON NERVOUS SYSTEM	1
105	5061	UNILATERAL THYROID LOBECTOMY	1
106	5062	OTHER PARTIAL THYROIDECTOMY	1
107	5066	EXCISION OF THYROGLOSSAL TRACT	2
108	5098	INCISION, EYELID	2
109	5091	EXCISION OR DESTRUCTION, EYELID	3
110	5092	OPERATIONS ON CANTHUS AND TARSUS	3

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WILLIAM BEAUMONT ARMY MEDICAL CENTER

CY 80

	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
111	5094	CORRECTION OF BLEPHAROPTOSIS	2
112	5095	BLEPHARORRHAPHY	5
113	5096	OTHER REPAIR OF EYELIDS	45
114	5099	OTHER OPERATIONS ON EYELIDS	1
115	5101	EXCISION OF OCULAR MUSCLE,TENDON W RE CESSION,ADVANCMENT	13
116	5102	ADVANCEMENT,RECES- SION OCULAR MUSCLE	26
117	5109	OTHER OPERATIONS ON OCULAR MUSCLE	1
118	5123	EXCISION,DESTRUC- TION,CORNEA LESION	1
119	5126	OTH REPAIR, CORNEA	2
120	5135	OTHER IRIDECTOMY OR IRIDOTOMY	4
121	5143	DISCISSION OF LENS AND CAPSULOTOMY	1
122	5144	INTRACAPSULAR EX- TRACTION OF LENS	33
123	5145	EXTRACAPSULAR EX- TRACTION OF LENS	1
124	5146	OTHER CATARACT EXTRACTION	1
125	5147	INSERTION OF PROSTHETIC LENS	3
126	5149	OTHER OPERATIONS ON LENS	1
127	5157	OPERATIONS ON VITREOUS	1

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WILLIAM BEAUMONT ARMY MEDICAL CENTER

CY 80

	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
128	5160	ORBITOTOMY	1
129	5181	EXCISION, DESTRUCTION OF LESION OF EXTERNAL EAR	2
130	5183	SUTURE OF EXTERNAL EAR	1
131	5184	SURGICAL CORRECTION, PROMINENT EAR	1
132	5185	RECONSTRUCTION OF EXTERNAL AUDITORY CANAL	5
133	5189	OTHER OPERATIONS ON EXTERNAL EAR	1
134	5191	STAPEDECTOMY	1
135	5194	MYRINGOPLASTY	5
136	5195	OTH TYMPANOPLASTY	4
137	5200	MYRINGOTOMY	17
138	5202	INCISION, MASTOID AND MIDDLE EAR	2
139	5203	MASTOIDECTOMY	4
140	5204	OTHER EXCISION OF MIDDLE EAR	1
141	5207	INCISION, DESTRUCTION OF INNER EAR	1
142	5209	OTHER OPERATIONS, MIDDLE, INNER EAR	3
143	5212	EXCISION, DESTRUCTION, LESION, NOSE	4
144	5214	SUBMUCOUS RESECTION, NASAL SEPTUM	3
145	5215	TURBINECTOMY	1
146	5217	REPAIR AND PLASTIC	29

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WILLIAM BEAUMONT ARMY MEDICAL CENTER
CY 80

	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
147	5219	OTHER OPERATIONS ON NOSE	1
148	5222	EXTERNAL MAXILLARY ANTROTOMY	2
149	5223	FRONTAL SINUSOTOMY AND SINUSECTOMY	1
150	5226	NASAL SINUS REPAIR	1
151	5229	OTHER OPERATIONS ON NASAL SINUSES	1
152	5230	FORCEPS EXTRACTION OF TOOTH	4
153	5231	SURGICAL REMOVAL OF TOOTH	15
154	5236	PROSTHETIC DENTAL IMPLANT	1
155	5240	INCISION OF GUM OR ALVEOLAR BONE	1
156	5243	EXCISION OF DENTAL LESION OF JAW	2
157	5244	ALVEOLOPLASTY	2
158	5246	APPLICATION, ORTHODONTIC APPLIANCE	6
159	5258	FRENOTOMY, LINGUAL	1
160	5270	DRAINAGE OF FACE OR FLOOR OF MOUTH	4
161	5272	EXCISION OF PALATE	1
162	5274	PLASTIC REPAIR OF MOUTH	2
163	5279	OTHER OPERATIONS ON MOUTH AND FACE	1
164	5280	ORAL DRAINAGE OF PHARYNGEAL ABSCESS	4

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CY 80

	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
165	5281	TONSILLECTOMY	11
166	5282	TONSILLECTOMY WITH ADENOIDECTOMY	3
167	5285	ADENOIDECTOMY	4
168	5291	EXCISION, BRANCHIAL CLEFT VESTIGES	3
169	5300	EXCISION OR DESTRUCTION LESION OF LARYNX	1
170	5311	TEMPORARY TRACHEOSTOMY	1
171	5340	INCISION OF CHEST WALL AND PLEURA	7
172	5347	OPERATIONS ON DIAPHRAGM	1
173	5351	OPEN HEART VALVOTOMY	1
174	5352	REPLACEMENT OF HEART VALVE	2
175	5361	BYPASS ANASTOMOSIS FOR HEART REVASCULARIZATION	2
176	5374	OTHER REPAIR OF HEART, PERICARDIUM	1
177	5377	IMPLANT OF CARDIAC PACEMAKER	4
178	5378	REMOVAL OR REPLACEMENT OF IMPLANTED CARDIAC PACEMAKER	1
179	5380	INCISION OF VESSEL	5
180	5381	ENDARTERECTOMY	1
181	5384	LIGATION AND STRIPPING OF VARICOSE VEINS	1

For Notes at End of Report 8.8

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WILLIAM BEAUMONT ARMY MEDICAL CENTER

CY 80

	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
182	5385	OTHER EXCISION OF VESSELS	1
183	5387	OTHER SURGICAL OCCLUSION OF VESSELS	1
184	5392	OTHER SHUNT OR VASCULAR BYPASS	1
185	5395	OTHER REPAIR OF VESSEL	1
186	5396	EXTRACORPOREAL CARDIOPULMONARY BYPASS	2
187	5399	OTHER OPERATIONS ON VESSELS	1
188	5400	INCISION OF LYMPHATIC STRUCTURES	2
189	5401	SIMPLE EXCISION OF LYMPHATIC STRUCTURE	1
190	5403	RADICAL EXCISION, CERVIC LYMPH NODES	1
191	5413	SPLENECTOMY	1
192	5428	MANIPULATION WITHIN ESOPHAGUS	4
193	5440	VAGOTOMY	1
194	5445	OTHER REPAIR OF STOMACH	1
195	5452	EXCISION, DESTRUCTION OF LESION OF LARGE INTESTINE	18
196	5470	APPENDECTOMY	16
197	5482	LOCAL EXCISION OR DESTRUCTION OF RECTUM	2
198	5486	REPAIR RECTUM	1

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WILLIAM BEAUMONT ARMY MEDICAL CENTER

CY 80

	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
199	5487	INCISION OR EXCISION OF PERIRECTAL TISSUE	4
200	5490	INCISION OR EXCISION OF PERIANAL TISSUE	2
201	5492	OTHER LOCAL EXCISION OR DESTRUCTION OF ANUS	1
202	5493	HEMORRHOIDECTOMY	2
203	5494	DIVISION OF ANAL SPHINCTER	2
204	5496	REPAIR OF ANUS	1
205	5530	REPAIR OF INGUINOFEMORAL HERNIA	46
206	5532	BILATERAL REPAIR OF INGUINOFEMORAL HERNIA	2
207	5534	REPAIR OF UMBILICAL HERNIA	7
208	5535	REPAIR OF OTHER HERNIA OF ANTERIOR ABDOMINAL WALL	2
209	5540	INCISION OF ABDOMINAL PARIETES	1
210	5541	LAPAROTOMY	2
211	5542	EXCISION, DESTRUCTION OF ABDOMINAL WALL AND UMBILICUS	2
212	5543	EXCISION, DESTRUCTION PERITONEUM	1
213	5571	CYSTOTOMY	2
214	5574	OTHER EXCISION OR DESTRUCTION OF BLADDER	1

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WILLIAM BEAUMONT ARMY MEDICAL CENTER
CY 80

INCIDENCE	SURG CODE	TITLE (ICPM)	FREQUENCY
215	5579	OTHER OPERATIONS ON URINARY BLADDER	1
216	5581	URETHRAL MEATOTOMY	2
217	5584	FREEING OF STRICTURE OF URETHRA	1
218	5585	DILATION, URETHRA	10
219	5598	URETERAL CATHETERIZATION	2
220	5601	TRANSURETHRAL PROSTATECTOMY	1
221	5610	INCISION SCROTUM, TUNICA VAGINALIS	1
222	5611	EXCISION, HYDROCELE	3
223	5619	OTHER OPERATIONS ON SCROTUM AND TUNICA VAGINALIS	3
224	5622	UNILATERAL ORCHIECTOMY	2
225	5624	ORCHIOPEXY	5
226	5640	CIRCUMCISION	15
227	5649	OTHER OPERATIONS, MALE GENITAL ORGAN	1
228	5657	FREEING ADHESIONS OF OVARY AND FALLOPIAN TUBE	2
229	5661	TOTL SALPINGECTOMY	3
230	5663	ENDOSCOPIC DESTRUCTION OF OCCLUSION OF FALLOPIAN TUBES	102
231	5664	OTHER DESTRUCTION OF OCCLUSION OF FALLOPIAN TUBES	29
232	5667	INSUFFLATATION OF FALLOPIAN TUBES	2

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CY 80

	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
233	5671	CONIZATION, CERVIX	7
234	5672	OTHER EXCISION OR DESTRUCTION OF LESION OF CERVIX	1
235	5674	REPAIR OF INTERNAL CERVICAL OS	1
236	5681	EXCISION OR DESTRUCTION LESION OF UTERUS	1
237	5684	VAGINAL HYSTERECTOMY	2
238	5690	D AND C OF UTERUS	234
239	5691	VAGINAL REMOVAL OF INTRAUTERINE FOREIGN BODY	6
240	5700	CULDOCENTESIS	8
241	5702	LOCAL EXCISION OR DESTRUCTION, VAGINA	4
242	5706	OTHER REPAIR OF VAGINA	1
243	5709	OTHER OPERATIONS ON VAGINA	1
244	5710	INCISION OF VULVA AND PERINEUM	1
245	5711	OPERATIONS ON BARTHOLINS GLAND	6
246	5712	OTH LOCAL EXCISION OR DESTRUCTION OF VULVA, PERINEUM	2
247	5720	LOW FORCEPS DELIVERY	1
248	5721	LOW FORCEPS DELIVERY W EPISIOTOMY	4
249	5728	VACUUM TRACTION OB	1

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
250	5730	ARTIFICAL RUPTURE OF MEMBRANES	9
251	5738	EPISIOTOMY	8
252	5750	AMNIOTIC INJECTION FOR TERMINATION OF PREGNANCY	5
253	5751	VACUUM ASPIRATION FOR TERMINATION OF PREGNANCY	2
254	5752	OTHER TERMINATION OF PREGNANCY	12
255	5753	AMNIOCENTESIS	21
256	5757	REPAIR OBSTETRIC LACERATION UTERUS	1
257	5758	REPAIR OTHER OB-STETRIC LACERATION	10
258	5761	OPEN REDUCTION OF ZYGOMATIC FRACTURE	1
259	5762	CLOSED REDUCTION MAXILLARY, MANDIB-ULAR FRACTURE	3
260	5771	EXCISION OR DESTRUCTION OF FACIAL BONE LESION	1
261	5772	PARTIAL OSTECTOMY OF FACIAL BONE EXCEPT MANDIBLE	2
262	5775	OTHER FACIAL BONE REPAIR,OSTEOPLASTY	1
263	5779	OTHER OPERATIONS ON FACIAL BONES AND JOINTS	1
264	5781	DIVISION OF BONE	8
265	5782	OSTECTOMY FOR HALLUX VALGUS	9

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
266	5783	EXCISION OF BONE LESION	6
267	5784	PARTIAL OSTECTOMY	5
268	5785	TOTAL OSTECTOMY	1
269	5788	REMOVAL INTERNAL FIXATION APPLIANCE	15
270	5790	CLOSED REDUCTION, FRACTURE WITH INTERNAL FIXATION	4
271	5791	OPEN REDUCTION OF FRACTURE	2
272	5792	OPEN REDUCTION OF FRACTURE WITH INTERNAL FIXATION	6
273	5795	TOILET OF OPEN FRACTURE SITE	8
274	5796	OPEN REDUCTION OF DISLOCATION JOINT	2
275	5800	ARTHROTOMY	5
276	5801	DIVISION OF JOINT CAPSULE, LIGAMENT OR CARTILAGE	3
277	5802	EXCISION OR DESTRUCTION LESION OF JOINT	3
278	5804	EXCISION SEMILUNAR CARTILAGE OF KNEE	3
279	5809	OTHER EXCISION OF JOINT STRUCTURE	1
280	5810	SPINAL FUSION	1
281	5811	ARTHRODESIS FOOT AND ANKLE	2
282	5812	ARTHRODESIS OF OTHER JOINTS	3

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
283	5813	ARTHROPLASTY OF FOOT AND TOE	7
284	5818	ARTHROPLASTY OF SHOULDER	1
285	5819	OTHER REPAIR OF JOINT STRUCTURE	1
286	5820	INCISION OF MUSCLE TENDON, FASCIA AND BURSA OF HAND	5
287	5821	DIVISION OF MUSCLE TENDON AND FASCIA OF HAND	14
288	5822	EXCISION OF LESION OF MUSCLE, TENDON AND FASCIA OF HAND	15
289	5824	SUTURE OF MUSCLE, TENDON,FASCIA,HAND	4
290	5828	OTHER PLASTIC OPERATIONS ON HAND	3
291	5829	OTHER OPERATIONS ON MUSCLE,TENDON AND FASCIA OF HAND	1
292	5830	INCISION OF MUSCLE TENDON, FASCIA AND BURSA	5
293	5831	DIVISION OF MUSCLE TENDON AND FASCIA	1
294	5832	EXCISION OF LESION OF MUSCLE, TENDON, FASCIA AND BURSA	1
295	5833	OTHER EXCISION OF MUSCLE,TENDON, AND FASCIA	2
296	5835	SUTURE OF MUSCLE, TENDON AND FASCIA	5
297	5837	OTHER PLASTIC OPERATIONS ON MUSCLE,	6

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
298	5839	OTHER OPERATIONS ON MUSCLE, TENDON, FASCIA AND BURSA	1
299	5840	AMPUTATION AND DISARTICULATION OF FINGERS	3
300	5845	AMPUTATION AND DISARTICULATION OF TOES	2
301	5850	REVISION OF AMPUTATION STUMP	5
302	5860	LOCAL EXCISION OF LESION OF BREAST	4
303	5869	OTHER EXCISION OF BREAST	1
304	5871	MASTOTOMY	5
305	5873	AUGMENTATION MAMMOPLASTY	13
306	5874	REDUCTION MAMMOPLASTY	3
307	5875	OTHER REPAIR AND PLASTIC OPERATION ON BREAST	3
308	5879	OTHER OPERATIONS ON BREAST	1
309	5881	INCISION OF PILONIDAL SINUS	3
310	5882	OTHER INCISION OF SKIN AND SUBCUTANEOUS TISSUE	27
311	5883	SURGICAL TOILET OF WOUND OR INFECTED TISSUE	17
312	5884	LOCAL EXCISION,DESTRUCTION,SKIN,SUBCUTANEOUS TISSUE	37

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
313	5885	RADICAL EXCISION OF SKIN LESION	1
314	5887	EXCISION OF PILONIDAL SINUS	3
315	5890	SUTURE OF SKIN AND SUBCUTANOUS TISSUE	21
316	5891	RELAXATION OF SCAR OR CONTRACTURE OF SKIN	4
317	5892	FREE SKIN GRAFT TO HAND	1
318	5893	OTHER FREE SKIN GRAFTS	5
319	5894	CUTTING AND PREPARATION OF FLAP OR PEDICLE GRAFT	3
320	5895	ATTACHMENT TO HAND OF FLAP OR PEDICLE GRAFT	1
321	5898	PLASTIC OPERATIONS LIP AND EXTERNAL MOUTH	7
322	5900	FACIAL RHYTIDECTOMY	2
323	5901	SIZE REDUCTION PLASTIC OPERATIONS	1
324	5912	PERINEAL CAUTERIZATION	1
325	5950	TOPICAL APPLICATION OF CAUSTIC	1
326	5954	CHEMOPEEL	4
327	5969	OTHER CYTOTOXIC DRUG THERAPY	38
328	5995	OPERATION NOT COMPLETED	5

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
329	8103	REMOVAL OF OBJECT BY AUROSCOPY AND FROM MEATUS	1
330	8104	REMOVAL OF OBJECT BY RHINOSCOPY	1
331	8105	REMOVAL OF ECOY BY LARYNGOSCOPY	1
332	8107	REMOVAL OF OBJECT BY BRONCHOSCOPY	1
333	8111	REMOVAL OF OBJECT BY PHARYNGOSCOPY AND ESOPHAGOSCOPY	3
334	8115	REMOVAL OF OBJECT FROM VAGINA	2
335	8116	REMOVAL OF OBJECT FROM SPECIFIED DERMAL SITE	3
336	8119	OTHER REMOVAL OF FOREIGN BODY	3
337	8123	GASTRIC IRRIGATION	1
338	8132	IRRIGATION BLADDER	1
339	8158	ASPIRATION HYGROMA CYST OR ABSCESS	1
340	8153	ASPIRATION OF PERICARDIAL SAC	1
341	8154	ASPIRATION OF BONE MARROW	2
342	8155	ASPIRATION OF PLEURAL CAVITY	3
343	8157	ASPIRATION OF PERITONEAL CAVITY	14
344	8168	ASPIRATION KIDNEY	3
345	8166	ASPIRATION, JOINT	

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
346	8169	OTHER ASPIRATION OF FLUID	1
347	8179	OTHER SYRINGING OR IRRIGATION	1
348	8182	DERMABRASION	1
349	8185	OTHER REMOVAL OF SKIN BLEMISHES	2
350	8186	REMOVAL OF NAIL	8
351	8190	WOUND CLEANING NOS	2
352	8200	CLOSED REDUCTION OF FRACTURE OF NASAL BONE	3
353	8202	CLOSED REDUCTION, FX UPPER ARM	8
354	8203	CLOSED REDUCTION, FX FOREARM, HAND	57
355	8205	CLOSED REDUCTION, FX LOWER LEG, FOOT	13
356	8209	CLOSED REDUCTION, DISLOCATION, JOINT	6
357	8225	DILATION OF BOWEL OR ARTIFICIAL ANUS	4
358	8250	ANTENATAL MANIPULATION NOS	1
359	8310	APPLICATION OF CAST	65
360	8319	CAST OR PLASTER IMMOBILIZATION	27
361	8324	SPLINTING FOR FRACTURE	8
362	8329	OTHER SPLINTING FOR IMMOBILIZATION	2
363	8334	WIRING OF TEETH	1

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
364	8389	REMOVAL OF OTHER FIXATION	1
365	8400	INFIXED BONE PIN	1
366	8412	OTHER CERVICAL TRACTION	1
367	8430	BALANCED SUSPENSON	9
368	8460	CERVICAL COLLAR FOR HEAD TRACTION	1
369	8460	REMOVAL OF INFIXED BONE PIN	1
370	8472	TRACTION FOR CLOSED FRACTURE	1
371	8474	TRACTION FOR DISLOCATION	2
372	8479	TRACTION OTHER AND UNQUALIFIED	3
373	8564	FITTING OF ARTIFICIAL LIMB	1
374	8570	INJECTION INTO SPINAL CANAL	3
375	8580	INJECTION INTO KIDNEY	1
376	8587	INJECTION INTO OTHER SPECIFIED TISSUE	1
377	8620	PHOTOTHERAPY	14
378	8640	EXTERNAL ELECTRODE STIMULATION	13
379	8651	EMERGENCY PACEMAKER	5
380	8709	TRACHEAL INTUBATION NOS	3
381	8710	MECHANICAL	1

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
382	8803	REPLACEMENT TRANSFUSION	1
383	8813	DRIED PLASMA INJECTION	1
384	8830	ARTERIAL CATHETERIZATION OR CANNULATION	1
385	8833	CATHETERIZATION OF UMBILICAL VESSEL	1
386	8835	CUT-DOWN VENOUS CATHETERIZATION OR CANNULATION	4
387	8851	OPERATIVE EXTERNAL CIRCULATION	1
388	8853	HEMODIALYSIS	11
389	8897	REMOVAL OF SUTURE OR CLIPS FROM SKIN WOUND	2
390	8961	MONITORING FETAL HEART DURING LABOR	13
391	8990	CLINICAL MONITORING	1
392	9251	INDUCTION BY INTRA VENOUS INJECTION OR DRIP	2
		TOTAL	2772

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
1	1272	CENTRAL VENOUS PRESSURE MEASURE	11
2	1273	INTRAVENOUS CATHETERIZATION, HEART	24
3	1275	RETROGRADE CATHETERIZATION OF LEFT HEART	24
4	1278	OTHER CATHETERIZATION OF HEART	1
5	1334	OTHER CYSTOMETRY	1
6	1363	ELECTROMYOGRAPHY	3
7	1420	BIOPSY OF LARYNX BY LARYNGOSCOPY	5
8	1422	TONSILS, FAUCES AND ADENOIDS BIOPSY	1
9	1425	BONE MARROW BIOPSY	4
10	1426	LYMPHATIC BIOPSY	6
11	1431	LUNG PERCUTANEOUS BIOPSY	1
12	1432	BIOPSY OF BRONCHUS BY ENDOSCOPY	1
13	1433	PLEURAL BIOPSY	1
14	1434	BIOPSY OF CHEST	1
15	1440	BIOPSY ESOPHAGUS BY ENDOSCOPY	2
16	1441	BIOPSY OF STOMACH BY ENDOSCOPY	1
17	1442	DUODENAL CAPSULE BIOPSY	1
18	1450	BIOPSY OF COLON BY ENDOSCOPY	10
19	1451	BIOPSY OF SIGMOID COLON BY ENDOSCOPY	1

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
20	1452	BIOPSY OF RECTUM BY ENDOSCOPY	3
21	1454	LIVER PERCUTANEOUS BIOPSY	8
22	1460	PERCUTANEOUS BIOPSY OF KIDNEY	5
23	1463	BIOPSY OF PROSTATE	17
24	1471	ENDOMETRIAL BIOPSY	4
25	1473	ENDOCERVICL BIOPSY	1
26	1475	OTHER,UNSPECIFIED CERVICAL BIOPSY	36
27	1477	BIOPSY INTROITUS	1
28	1482	BREAST BIOPSY	1
29	1484	BONE OR JOINT BIOPSY	1
30	1500	SURGICAL BIOPSY OF SKIN, SUBCUTANEOUS TISSUE	2
31	1501	SURGICAL BIOPSY OF BREAST	4
32	1502	SURGICAL BIOPSY OF MUSCLE	2
33	1538	SURGICAL BIOPSY OF NOSE, OTHER PARTS	1
34	1540	SURGICL BIOPSY,LIP	1
35	1548	SURGICAL BIOPSY OF NASOPHARYNX	1
36	1551	SURGICAL BIOPSY OF LIVER	1
37	1557	SURGICAL BIOPSY OF RECTUM	1
38	1562	SURGICAL BIOPSY OF OTH URINARY ORGANS	1

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
39	1563	SURGICAL BIOPSY OF PROSTATE	1
40	1565	SURGICAL BIOPSY OF TESTIS	3
41	1571	SURGICAL BIOPSY OF CERVIX	1
42	1573	SURGICAL BIOPSY OF VULVA	1
43	1581	SURGICAL BIOPSY OF OTHER MEDIASTINAL, THORACIC ORGAN	1
44	1586	SURGICAL BIOPSY OF SUPERFICIAL LYMPH NODE	3
45	1599	SURGICL BIOPSY NOS	1
46	1610	DIAGNOSTIC LARYNGOSCOPIC PROCEDURES	1
47	1612	DIRECT LARYNGOSCOPY	4
48	1630	ESOPHAGOSCOPY	6
49	1633	GASTROSCOPY	5
50	1641	COLONOSCOPY	27
51	1642	SIGMOIDOSCOPY	2
52	1643	PROCTOSCOPY	11
53	1652	CYSTOSCOPY	21
54	1653	PANENDOSCOPY	1
55	1655	URETHROSCOPY	2
56	1663	COLPOSCOPY	9
57	1679	OTHER SPECIFIED ENDOSCOPY	26
58	1689	ENDOSCOPY NOS	6

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
59	1690	BRONCHOSCOPY, TRACHEOSCOPY BY MEANS OF TRACHEOTOMY	1
60	1694	LAPAROSCOPY	57
61	1695	OPERATIVE ENTEROSCOPY OR OTHER ABDOMINAL ENDOSCOPY	2
62	1697	ARTHROSCOPY	1
63	1710	MEASUREMENT OF LUNG VOLUMES	1
64	1724	EXERCISE TOLERANCE TESTS	1
65	1830	PROBING OF LACRIMAL PASSAGES	10
66	1831	PROBING OF NASOLACRIMAL DUCT	21
67	1854	DIAGNOSTIC JOINT ASPIRATION	3
68	1859	OTHER AND UNSPECIFIED ASPIRATION	3
69	1860	DIAGNOSTIC CATHETERIZATION OF VEIN OF ORGAN	1
70	3211	MYELOGRAPHY	25
71	3251	INTRAVENOUS UROGRAPHY	35
72	3253	RETROGRADE UROGRAPHY	25
73	3257	CYSTOGRAPHY	16
74	3262	OPERATIVE CHOLANGIOGRAPHY	4
75	3273	HYSTEROSALPINGOGRAPHY	5

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
76	3297	ARTHROGRAPHY	3
77	3309	ARTERIOGRAPHY OF HEAD AND NECK	29
78	3312	ARTERIOGRAPHY, CORONARY	12
79	3318	ANGIOCARDIOGRAPHY	12
80	3335	ARTERIOGRAPHY, RENAL	10
81	3338	AORTOGRAPHY	20
82	3339	OTHER ARIERIOG-RAPHY OF TRUNK	3
83	3349	ARTERIOGRAPHY OF EXTREMITIES	13
84	3379	VENOGRAPHY	6
85	3389	LYMPHANGIOGRAPHY AND LYMPHADENOG-RAPHY	2
86	3429	TOMOGRAPHY	15
87	3440	COMPUTERIZED AXIAL TOMOGRAPHY OF HEAD	64
88	3448	OTHER COMPUTERIZED AXIAL TOMOGRAPHY	8
89	3519	RADIOISOTOPE SCAN, FUNCTION STUDY	43
90	3599	OTHER NUCLEAR DIAG NOSTIC PROCEDURES	2
91	3619	DIAGNOSTIC ULTRA-SOUND	46
92	3699	OTHER DIAGNOSTIC RADIOLOGICAL PROCEDURES	10
93	3713	ORTHOVOLTAGE RADIATION	5

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
94	3839	INJECTION OR INSTILLAION OF RADIOISOTOPES	1
95	3899	OTHER RADIOTHERAPEUTIC AND NUCLEAR MEDICINE PROCEDURE	1
96	5022	VENTRICULOSTOMY	1
97	5024	REVISION OF VENTRICULAR SHUNT	4
98	5041	OTHER DESTRUCTION OF NERVE	1
99	5042	SUTURE OF NERVE	10
100	5043	FREEING ADHESIONS, DECOMPRESS NERVE	14
101	5047	INJECTION INTO NERVE	3
102	5052	INJECTION INTO SYMPATHETIC NERVE OR GANGLION	1
103	5062	OTHER PARTIAL THYROIDECTOMY	1
104	5066	EXCISION OF THYROGLOSSAL TRACT	4
105	5086	REPAIR CANALICULUS AND PUNCTUM	1
106	5088	CONJUNCTIVO-RHINOSTOMY	1
107	5089	OTHER OPERATIONS, LACRIMAL APPARATUS	1
108	5092	OPERATIONS ON CANTHUS AND TARSUS	2
109	5094	CORRECTION OF BLEPHAROPTOSIS	2
110	5095	BLEPHARORRHAPHY	2

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
111	5096	OTHER REPAIR OF EYELIDS	32
112	5101	EXCISION OF OCULAR MUSCLE,TENDON W RECESSION,ADVANCMENT	13
113	5102	ADVANCEMENT,RECESSION OCULAR MUSCLE	43
114	5104	OTHER SHORTENING OF OCULAR MUSCLE	1
115	5109	OTHER OPERATIONS ON OCULAR MUSCLE	1
116	5129	OTHER OPERATIONS ON CORNEA	1
117	5137	SCLEROPLASTY	1
118	5139	OTHER OPERATIONS, IRIS,CILIARY BODY, ANTERIOR CHAMBER	1
119	5144	INTRACAPSULAR EXTRACTION OF LENS	12
120	5145	EXTRACAPSULAR EXTRACTION OF LENS	4
121	5146	OTHER CATARACT EXTRACTION	3
122	5147	INSERTION OF PROSTHETIC LENS	6
123	5154	OTHER OPERATIONS, REPAIR OF RETINA	1
124	5160	ORBITOTOMY	1
125	5164	EXCISION OR DESTRUCTION OF ORBITAL CONTENTS	1
126	5166	REMOVAL OF ORBITAL IMPLANT	2
127	5167	REPAIR OF ORBIT	1

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
128	5169	OTHER OPERATIONS ON ORBIT AND EYE	1
129	5180	INCISION OF EXTERNAL EAR	1
130	5181	EXCISION, DESTRUCTION OF LESION OF EXTERNAL EAR	2
131	5184	SURGICAL CORRECTION, PROMINENT EAR	1
132	5185	RECONSTRUCTION OF EXTERNAL AUDITORY CANAL	1
133	5191	STAPEDECTOMY	3
134	5193	OTHER OPERATIONS ON OSSICULAR CHAIN	4
135	5194	MYRINGOPLASTY	10
136	5195	OTH TYMPANOPLASTY	4
137	5196	REVISION OF TYMPANOPLASTY	2
138	5200	MYRINGOTOMY	27
139	5202	INCISION, MASTOID AND MIDDLE EAR	3
140	5203	MASTOIDECTOMY	4
141	5204	OTHER EXCISION OF MIDDLE EAR	1
142	5209	OTHER OPERATIONS, MIDDLE, INNER EAR	8
143	5211	INCISION OF NOSE	2
144	5212	EXCISION, DESTRUCTION, LESION, NOSE	7
145	5214	SUBMUCOUS RESECTION, NASAL SEPTUM	13

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	INCIDENCE SURG CODE	E (ICPM)	FREQUENCY
146	5216	OPEN REDUCTION OF FRACTURE OF NASAL BONE	1
147	5217	REPAIR AND PLASTIC OPERATIONS ON NOSE	28
148	5219	OTHER OPERATIONS ON NOSE	1
149	5222	EXTERNAL MAXILLARY ANTROTOMY	2
150	5223	FRONTAL SINUSOTOMY AND SINUSECTOMY	1
151	5225	OTHER NASAL SINUSECTOMY	4
152	5230	FORCEPS EXTRACTION OF TOOTH	2
153	5231	SURGICAL REMOVAL OF TOOTH	40
154	5232	RESTORATION, TOOTH BY FILLING	3
155	5237	APICECTOMY AND ROOT CANAL THERAPY	1
156	5242	OTHER OPERATIONS ON GUM	2
157	5243	EXCISION OF CENTAL LESION OF JAW	4
158	5244	ALVEOLOPLASTY	8
159	5246	APPLICATION, ORTHODONTIC APPLIANCE	6
160	5249	OTHER DENTAL OPERATION	1
161	5259	OTHER OPERATIONS ON TONGUE	1
162	5261	EXCISION OF LESION OF SALIVARY GLAND	2

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
163	5262	OTHER EXCISION OF SALIVARY GLAND	1
164	5270	DRAINAGE OF FACE OR FLOOR OF MOUTH	4
165	5274	PLASTIC REPAIR OF MOUTH	3
166	5280	ORAL DRAINAGE OF PHARYNGEAL ABSCESS	6
167	5281	TONSILLECTOMY	15
168	5282	TONSILLECTOMY WITH ADENOIDECTOMY	6
169	5285	ADENOIDECTOMY	3
170	5300	EXCISION OR DESTRUCTION LESION OF LARYNX	2
171	5321	OTHER EXCISION OF BRONCHUS	2
172	5340	INCISION OF CHEST WALL AND PLEURA	4
173	5346	REPAIR CHEST WALL	1
174	5349	OTHER OPERATIONS ON THORAX	1
175	5378	PERICARDIOCENTESIS	1
176	5377	IMPLANT OF CARDIAC PACEMAKER	3
177	5380	INCISION OF VESSEL	1
178	5387	OTHER SURGICAL OCCLUSION OF VESSELS	3
179	5390	SYSTEMIC PULMONARY ARTERIAL SHUNT	1
180	5393	SUTURE OF VESSEL	3
181	5394	REVISION OF VASCULAR PROCEDURE	2

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
182	5395	OTHER REPAIR OF VESSEL	6
183	5401	SIMPLE EXCISION OF LYMPHATIC STRUCTURE	4
184	5413	SPLENECTOMY	2
185	5428	MANIPULATION WITHIN ESOPHAGUS	2
186	5445	OTHER REPAIR OF STOMACH	1
187	5452	EXCISION, DESTRUCTION OF LESION OF LARGE INTESTINE	5
188	5467	OTHER REPAIR OF INTESTINE	1
189	5478	APPENDECTOMY	54
190	5480	PROCTOTOMY	1
191	5482	LOCAL EXCISION OR DESTRUCTION OF RECTUM	1
192	5486	REPAIR RECTUM	1
193	5487	INCISION OR EXCISION OF PERIRECTAL TISSUE	7
194	5490	INCISION OR EXCISION OF PERIANAL TISSUE	1
195	5491	INCISION OR EXCISION OF ANAL FISTULA	5
196	5492	OTHER LOCAL EXCISION OR DESTRUCTION OF ANUS	2
197	5494	DIVISION OF ANAL SPHINCTER	3

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
198	5501	LOCAL EXCISION OR DESTRUCTION OF LIVER	1
199	5511	CHOLECYSTECTOMY	2
200	5530	REPAIR OF INGUINO-FEMORAL HERNIA	68
201	5532	BILATERAL REPAIR OF INGUINOFEMORAL HERNIA	1
202	5534	REPAIR OF UMBILICAL HERNIA	8
203	5535	REPAIR OF OTHER HERNIA OF ANTERIOR ABDOMINAL WALL	2
204	5548	INCISION OF ABDOMINAL PARIETES	1
205	5541	LAPAROTOMY	7
206	5542	EXCISION, DESTRUCTION OF ABDOMINAL WALL AND UMBILICUS	7
207	5561	URETERAL HEATOTOMY	1
208	5562	URETEROTOMY	1
209	5581	URETHRAL HEATOTOMY	2
210	5582	EXCISION OR DESTRUCTION URETHRA	1
211	5583	REPAIR OF URETHRA	2
212	5585	DILATION, URETHRA	10
213	5589	OTHER OPERATIONS ON URETHRA	2
214	5610	INCISION SCROTUM, TUNICA VAGINALIS	3
215	5611	EXCISION, HYDROCELE	8

** See Notes at End of Report **

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INCIDENCE	SURG CODE	TITLE (ICPM)	FREQUENCY
216	5620	INCISION OF TESTIS	1
217	5621	EXCISION, DESTRUCTION TESTIS LESION	1
218	5622	UNILATERAL ORCHIECTOMY	2
219	5623	BILATERIAL ORCHIECTOMY	3
220	5624	ORCHIOPEXY	10
221	5629	OTHER OPERATIONS ON TESTIS	1
222	5630	EXCISION OF VARICOCELE AND HYDROCELE OF SPERMATIC CORD	8
223	5637	REPAIR EPIDIDYMIS AND VAS DEFERENS	2
224	5640	CIRCUMCISION	14
225	5649	OTHER OPERATIONS, MALE GENITAL ORGAN	3
226	5651	LOCAL EXCISION OR DESTRUCTION OVARY	2
227	5653	UNILATERL SALPINGO OOPHORECTOMY	2
228	5656	REPAIR OF OVARY	1
229	5661	TOTL SALPINGECTOMY	1
230	5663	ENDOSCOPIC DESTRUCTION OF OCCLUSION OF FALLOPIAN TUBES	125
231	5664	OTHER DESTRUCTION OF OCCLUSION OF FALLOPIAN TUBES	23
232	5667	INSUFFLATATION OF FALLOPIAN TUBES	1
233	5671	CONIZATION, CERVIX	4

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
234	5672	OTHER EXCISION OR DESTRUCTION OF LESION OF CERVIX	4
235	5674	REPAIR OF INTERNAL CERVICAL OS	1
236	5681	EXCISION OR DESTRUCTION LESION OF UTERUS	1
237	5690	D AND C OF UTERUS	207
238	5691	VAGINAL REMOVAL OF INTRAUTERINE FOREIGN BODY	11
239	5699	OTHER OPERATIONS, UTERUS,CERVIX AND SUPPORT STRUCTURE	1
240	5700	CULDOCENTESIS	3
241	5702	LOCAL EXCISION OR DESTRUCTION,VAGINA	1
242	5709	OTHER OPERATIONS ON VAGINA	1
243	5711	OPERATIONS ON BARTHOLINS GLAND	6
244	5712	OTH LOCAL EXCISION OR DESTRUCTION OF VULVA, PERINEUM	2
245	5716	REPAIR OF VULVA AND PERINEUM	4
246	5721	LOW FORCEPS DELIVERY W EPISIOTOMY	1
247	5730	ARTIFICAL RUPTURE OF MEMBRANES	2
248	5738	EPISIOTOMY	3
249	5751	VACUUM ASPIRATION FOR TERMINATION OF PREGNANCY	1

* * See Notes at End of Report * *

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CY 81

INCIDENCE	SURG CODE	TITLE (ICPM)	FREQUENCY
250	5753	AMNIOCENTESIS	24
251	5756	REMOVAL OF RETAINED PLACENTA	1
252	5757	REPAIR OBSTETRIC LACERATION UTERUS	1
253	5758	REPAIR OTHER OBSTETRIC LACERATION	6
254	5762	CLOSED REDUCTION MAXILLARY, MANDIBULAR FRACTURE	10
255	5767	OTHER OPEN REDUCTION OF FACIAL FX	1
256	5770	INCISION OF FACIAL BONES	1
257	5772	PARTIAL OSTECTOMY OF FACIAL BONE EXCEPT MANDIBLE	1
258	5773	EXCISION AND RECONSTRUCTION OF MANDIBLE	2
259	5775	OTHER FACIAL BONE REPAIR,OSTEOPLASTY	2
260	5779	OTHER OPERATIONS ON FACIAL BONES AND JOINTS	1
261	5780	INCISION OF BONE	1
262	5781	DIVISION OF BONE	1
263	5782	OSTECTOMY FOR HALLUX VALGUS	4
264	5783	EXCISION OF BONE LESION	2
265	5784	PARTIAL OSTECTOMY	2
266	5786	BONE GRAFT	2

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
267	5788	REMOVAL INTERNAL FIXATION APPLIANCE	16
268	5789	OTHER OPERATIONS ON BONE	1
269	5792	OPEN REDUCTION OF FRACTURE WITH INTERNAL FIXATION	14
270	5795	TOILET OF OPEN FRACTURE SITE	5
271	5797	OPERATIONS FOR MULTIPLE FRACTURES AND INJURIES NEC	1
272	5800	ARTHROTOMY	3
273	5801	DIVISION OF JOINT CAPSULE, LIGAMENT OR CARTILAGE	7
274	5802	EXCISION OR DESTRUCTION LESION OF JOINT	3
275	5804	EXCISION SEMILUNAR CARTILAGE OF KNEE	1
276	5809	OTHER EXCISION OF JOINT STRUCTURE	1
277	5811	ARTHRODESIS FOOT AND ANKLE	3
278	5812	ARTHRODESIS OF OTHER JOINTS	2
279	5813	ARTHROPLASTY OF FOOT AND TOE	4
280	5814	ARTHROPLASTY, KNEE	1
281	5817	ARTHROPLASTY OF HAND AND FINGER	1
282	5818	ARTHROPLASTY OF SHOULDER	2

** See Notes at End of Report **

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
283	5819	OTHER REPAIR OF JOINT STRUCTURE	2
284	5820	INCISION OF MUSCLE TENDON, FASCIA AND BURSA OF HAND	2
285	5821	DIVISION OF MUSCLE TENDON AND FASCIA OF HAND	13
286	5822	EXCISION OF LESION OF MUSCLE, TENDON AND FASCIA OF HAND	7
287	5824	SUTURE OF MUSCLE, TENDON,FASCIA,HAND	6
288	5827	PLASTIC OPERATION ON HAND WITH GRAFT OR IMPLANT	1
289	5828	OTHER PLASTIC OPERATIONS ON HAND	2
290	5829	OTHER OPERATIONS ON MUSCLE,TENDON AND FASCIA OF HAND	2
291	5830	INCISION OF MUSCLE TENDON, FASCIA AND BURSA	3
292	5831	DIVISION OF MUSCLE TENDON AND FASCIA	4
293	5832	EXCISION OF LESION OF MUSCLE, TENDON, FASCIA AND BURSA	2
294	5833	OTHER EXCISION OF MUSCLE,TENDON, AND FASCIA	2
295	5835	SUTURE OF MUSCLE, TENDON AND FASCIA	7
296	5836	RECONSTRUCTION OF MUSCLE AND TENDON	2

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	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
297	5837	OTHER PLASTIC OPERATIONS ON MUSCLE, TENDON AND FASCIA	11
298	5848	AMPUTATION THIGH, DISARTICULATION AT KNEE	1
299	5849	ABDOMINOPELVIC AMPUTATION AND DISARTICULATION HIP	1
300	5851	REATTACHMENT OF FINGERS AND THUMB	1
301	5859	OTHER OPERATIONS, MUSCULOSKELETAL, MULTIPLE SYSTEM	1
302	5860	LOCAL EXCISION OF LESION OF BREAST	2
303	5871	MASTOTOMY	8
304	5872	BREAST NIPPLE OPERATION	2
305	5873	AUGMENTATION MAMMOPLASTY	21
306	5874	REDUCTION MAMMOPLASTY	6
307	5875	OTHER REPAIR AND PLASTIC OPERATION ON BREAST	14
308	5879	OTHER OPERATIONS ON BREAST	1
309	5881	INCISION OF PILONIDAL SINUS	3
310	5882	OTHER INCISION OF SKIN AND SUBCUTANEOUS TISSUE	23
311	5883	SURGICAL TOILET OF WOUND OR INFECTED TISSUE	29

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CY 81

INCIDENCE	SURG CODE	TITLE (ICPM)	FREQUENCY
312	5884	LOCAL EXCISION, DESTRUCTION, SKIN, SUBCUTANEOUS TISSUE	29
313	5885	RADICAL EXCISION OF SKIN LESION	1
314	5890	SUTURE OF SKIN AND SUBCUTANOUS TISSUE	22
315	5891	RELAXATION OF SCAR OR CONTRACTURE OF SKIN	7
316	5892	FREE SKIN GRAFT TO HAND	2
317	5893	OTHER FREE SKIN GRAFTS	1
318	5894	CUTTING AND PREPARATION OF FLAP OR PEDICLE GRAFT	2
319	5895	ATTACHMENT TO HAND OF FLAP OR PEDICLE GRAFT	1
320	5900	FACIAL RHYTIDECTOMY	5
321	5909	OTHER OPERATIONS	1
322	5912	PERINEAL CAUTERIZATION	1
323	5969	OTHER CYTOTOXIC DRUG THERAPY	30
324	5970	INTRAVENOUS SCLEROSING INJECTION	1
325	5982	OTHER SURGICAL OPERATIONS FOR PREVENTIVE PURPOSE	2
326	5995	OPERATION NOT COMPLETED	17
327	8103	REMOVAL OF OBJECT	1

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CY 1

	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
328	8107	REMOVAL OF OBJECT BY BRONCHOSCOPY	1
329	8110	REMOVAL OF OBJECT FROM MOUTH AND NASOPHARYNX	1
330	8111	REMOVAL OF OBJECT BY PHARYNGOSCOPY AND ESOPHAGOSCOPY	6
331	8119	OTHER REMOVAL OF FOREIGN BODY	2
332	8123	GASTRIC IRRIGATION	4
333	8141	LACRIMAL DUCT CATHETERIZATION	1
334	8150	ASPIRATION HYGROMA CYST OR ABSCESS	1
335	8155	ASPIRATION OF PLEURAL CAVITY	4
336	8157	ASPIRATION OF PERITONEAL CAVITY	6
337	8160	ASPIRATION KIDNEY	1
338	8166	ASPIRATION, JOINT	3
339	8167	ASPIRATION, OTHER MUSCULOSKELETAL STRUCTURES	1
340	8187	LIGATION OF DERMAL PROTUBERANCE	1
341	8190	WOUND CLEANING NOS	1
342	8191	TOILET OF WOUND NOS	1
343	8192	DRESSING OF WOUND	1
344	8208	CLOSED REDUCTION OF FRACTURE OF NASAL BONE	2

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CY 81

	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
345	8202	CLOSED REDUCTION, FX UPPER ARM	32
346	8203	CLOSED REDUCTION, FX FOREARM, HAND	43
347	8204	CLOSED REDUCTION, FX UPPER LEG	6
348	8205	CLOSED REDUCTION, FX LOWER LEG, FOOT	20
349	8208	CLOSED REDUCTION OF OTHER FRACTURE	1
350	8209	CLOSED REDUCTION, DISLOCATION, JOINT	9
351	8217	MANIPULATION UNDER ANESTHESIA	1
352	8225	DILATION OF BOWEL OR ARTIFICIAL ANUS	1
353	8310	APPLICATION OF CAST	65
354	8313	REPLACEMENT OF CAST OR JACKET	3
355	8319	CAST OR PLASTER IMMOBILIZATION	55
356	8321	SPLINTING OF FINGER	1
357	8324	SPLINTING FOR FRACTURE	4
358	8330	EXTERNAL FIXATION OF FRACTURED BONE	1
359	8332	OTHER IMMOBILIZATION OF BONE	2
360	8360	REMOVAL OF CAST, MOLD OR SUPPORT	2
361	8430	BALANCED SUSPENSON	11

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CY 81

	INCIDENCE	SURG CODE	TITLE (ICPM)	FREQUENCY
362		8472	TRACTION FOR CLOSED FRACTURE	2
363		8474	TRACTION FOR DISLOCATION	1
364		8504	CONTROL OF VAGINAL HEMORRHAGE	1
365		8584	INJECTION INTO JOINT OR LIGAMENT	2
366		8585	INJECTION INTO MUSCLE, TENDON OR BURSA	1
367		8587	INJECTION INTO OTHER SPECIFIED TISSUE	1
368		8620	PHOTOTHERAPY	9
369		8640	EXTERNAL ELECTRODE STIMULATION	18
370		8651	EMERGENCY PACE-MAKER	6
371		8700	INSERTION OF ENDO TRACHEAL TUBE	2
372		8709	TRACHEAL INTUBA-TION NOS	6
373		8710	MECHANICAL VENTILATION	1
374		8805	TRANSFUSION OF PACKED BLOOD CELLS	1
375		8830	ARTERIAL CATHETER-IZATION OR CANNU-LATION	14
376		8831	FEMORAL ARTERY CANNULIZATION	1
377		8834	VENOUS CATHETERI-ZATION,CANNULATION	4

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CY 81

	INCIDENCE SURG CODE	TITLE (ICPM)	FREQUENCY
378	8835	CUT-DOWN VENOUS CATHETERIZATION OR CANNULATION	1
379	8853	HEMODIALYSIS	2
380	8860	PERITONEAL DIALYSIS	1
381	8881	REPLACEMENT OF SUB CUTANEOUS PULSE GENERATOR, BATTERY	2
382	8944	PLETHYSMOGRAPHIC MONITORING	1
383	8961	MONITORING FETAL HEART DURING LABOR	2
		TOTAL	2727

Footnotes:

Due to the large number of procedures involved, data are not presented on a monthly basis and no days are included.

SOURCE: Individual Patient Data System (IPDS) (RCS MED-345)

PREPARED BY:
Department of the Army
US Army Patient Administration Systems
and Biostatistics Activity
HSHI-QBS
11 FEB 1982

APPENDIX E

Proposed Procedural Guide for WBAMC Ambulatory Surgery Program

PROPOSED PROCEDURAL GUIDE FOR WBAMC
AMBULATORY SURGERY PROGRAM

I. OBJECTIVES.

The purpose of the Ambulatory Surgery Program is to provide a flexible, effective, and safe means by which patients not otherwise requiring hospitalization can receive necessary surgery on an ambulatory basis, and not remain in the hospital overnight. The primary goal of this program is to remove certain categories of surgical patients from beds in an effort to more efficiently utilize existing hospital resources and staff.

II. PROGRAM DESCRIPTION.

The Ambulatory Surgery Program will be integrated into the existing facilities. A separate ambulatory surgery nursing unit (ASNU), organized under the Department of Nursing, will be established on Ward 10 East, and will provide the necessary nursing and administrative services to patients enrolled in the program. Program events are divided into three different days: Day of Referral, Day of Pre-anesthesia Interview; and Day of Surgery. Specific events and responsibilities will be discussed below. Patients will be formally admitted to the hospital, but will not remain overnight under normal circumstances.

III. PROGRAM ADMINISTRATION.

A. An ambulatory surgery executive committee will provide overall direction and supervision to the program.

B. Committee members are:

1. Chief, Department of Surgery, Chairman
2. Chief, Department of Orthopaedics
3. Chief, Department of Obstetrics/Gynecology
4. Chief, Anesthesia Service
5. Head Nurse, ASNU
6. Administrator, CPS
7. Senior representatives from the following departments.
   Patient Administration Division
   Department of Radiology
   Department of Pathology

C. Committee responsibilities are:

1. Directing/supervising program.
2. Formulating/maintaining a current list of approved ambulatory surgery procedures. (Clinical chiefs only)
3. Establishing patient selection criteria.

4. Problem-solving.
5. Monitoring quality/utilization.
6. Staff education.
7. Reporting to hospital-wide Quality Assurance Program.

IV. SELECTION OF PATIENTS

Only ASA Class I and II patients will be considered for program enrollment. The attending physician is responsible for making patient selection. Single patients living alone or in a barracks will not normally be enrolled.

V. CONTINUING EDUCATION FOR ASNU EMPLOYEES

The Chief, Department of Nursing will be responsible for continuing education. Other participating departments will assist as necessary.

VI. MEDICAL STAFF PRIVILEGES

Medical staff privileges for ambulatory surgery remain unchanged from existing credentials. Each participating physician will receive a thorough briefing in ambulatory patient requirements and system policies/procedures.

VII. TASKS AND RESPONSIBILITIES

Tasks and responsibilities of those associated with WBAMC's ambulatory surgery program, listed in approximate chronological order are as follows:

A. DAY OF REFERRAL

1. Physician: upon determination that a patient is eligible for ambulatory surgery (ASA Class I or II patients), the following actions must be completed prior to referral.

a. Establish firm date and time for the surgical procedure.

b. Complete the following forms and give to the patient with instructions as to where each is to be taken:

(1) IAS Admission Record (HSC Form 348R), blocks 1 thru 7. Take to Admission and Disposition Office, Patient Administration Division.

(2) All required requests for pre-operative testing. To be taken to the appropriate testing area. Completed tests are to be forwarded to Ward 10 AS.

c. Complete the following forms and forward to the Ambulatory Surgery Nursing Unit (ASNU).

(1) Standard Form 539, Abbreviated Medical Record. This form can be used only for ASA Class I patients. ASA Class II patients require the same forms used for surgical inpatients.

(2) Standard Form 522, Request for Administration of Anesthesia and for Performance of Operations and Other Surgical Procedures. A brief description of the surgical procedure should be written in terms understandable to the patient. This consent form must be signed by the physician, indicating that the patient has been counseled for the specific procedures noted. The patient and one witness must also sign the operative permit.

(3) DA Form 4107, Operation Request and Worksheet. This form is used to request instruments, sutures, type of preparation required, and any special instructions. Scheduled date and time of the procedure must be entered.

(4) Standard Form 517, Pre-anesthetic Summary. Referring physician completes and signs the front side only.

2. Referring Clinic Clerk/Secretary: will insure that all necessary ambulatory surgery forms have been properly completed and assembled. Insures that the patient has received the required requests for diagnostic testing. Proper entries will be made to the clinic's projected OR schedule. A telephone call will be made to the ASNU clerk prior to the patient leaving the clinic to advise of the referral. In the event a referral is made late in the day, it may be necessary for the day of referral activities to be postponed to another day. The clinic clerk/secretary is responsible for handcarrying required forms to the ASNU clerk not later than the day following the referral.

3. PAD Admissions Clerk:

a. Complete all required pre-admission forms IAW PAD Standing Operating Procedure 3.

b. Place the pre-admission package in a manila folder and instruct the patient to handcarry the folder to the ASNU, located on Ward 10E.

c. Advise the patient that a one day per diem charge will be made (give amount for type of patient), which will automatically be billed to patient's mailing address, unless patient elects to make payment upon discharge.

d. Instruct patient to leave all valuables at home if possible.

4. Ambulatory Surgery Nursing Unit:

a. Head Nurse (or designee):

(1) Determine patient's day and time of surgery and the type of procedure to be performed.

(2) Establish pre-anesthesia interview appointment (NLT 24 hours prior to the surgery).

(3) Review pre-admission file for completeness and give to ward clerk for processing.

(4) Orient patient to the ASNU and conduct pre-operative nursing assessment and teaching; provide appropriate written instructions. (NOTE: pre-operative assessment and teaching can be performed on the day of pre-anesthesia interview, if desired.)

(5) Make preliminary nursing assessment notes.

(6) Instruct patient to report to ASNU to pick up file prior to pre-anesthesia interview.

b. Ward Clerk:

(1) Responsible for coordination of schedules with the referring clinic. Advise clinic if a proposed day of surgery cannot be accommodated by the ASNU.

(2) Responsible for picking up all pre-admission packages in the PAD at least once per day. Separate files are to be maintained on each patient, suspensed to the day prior to pre-anesthesia interview.

(3) Maintain a checklist of forms received and/or required for each patient. Insure that all required forms are on hand not later than the day prior to the scheduled pre-anesthesia interview. This is critical since the anesthesiologist/nurse anesthetist must review the forms during the interview.

B. DAY OF PRE-ANESTHESIA INTERVIEW

1. Ambulatory Surgery Nursing Unit:

a. Head Nurse.

(1) Reiterate any pertinent pre-operative instructions; answer any questions.

(2) Instruct the patient as to the time he/she is to report to the ASNU on the day of surgery.

(3) Instruct patient to report to anesthesia interview area with file.

b. Ward Clerk.

(1) Provide patient his/her file after insuring completeness.

(2) Collect all patient files from the OR office at the end of the shift and re-file suspensed to day of surgery.

2. Anesthesiologist/Nurse Anesthetist:

a. Perform examination on any patient scheduled for general anesthesia.

b. Make judgment concerning suitability of patient for general anesthesia in the ambulatory setting, contacting surgeon if this judgment is negative.

c. Arrange alternative measures when necessary.

d. Complete pre-anesthetic summary (SF 517), as required.

e. Provide indicated pre-anesthesia counseling.

C. DAY OF SURGERY

1. ASNU Staff (For Reception/Preparation):

a. In-process patient

(1) Review file for completeness.

(2) After making positive identification, affix patient identification bracelet.

(3) Notify PAD of admission.

(4) Escort patient to preparation/gowning area.

b. Assist patient in gowning as necessary.

c. Accomplish pre-operative preparation of patient as required.

d. Hold patient until the appointed time for transfer to the main OR suite. NOTE: Patient may have visitors while in the holding area.

e. Transfer patient at appointed time.

f. Direct patient's family/visitors to appropriate waiting area.

2. Operating Room Staff: No change to existing procedures.

3. Recovery Room Staff: No change to existing procedures. Ambulatory surgery patients are to be transferred to the ASNU (Ward 10E) for second stage recovery and discharge when post anesthesia recovery (PAR) criteria are attained.

4. ASNU Staff (For Recovery/Discharge)

a. Place the patient in the second stage recovery area and reunite patient with family/friends.

b. Closely monitor patient's recovery process and note when the various discharge criteria have been accomplished by the patient. The following criteria are recommended and may be amended by proper medical authority:

(1) Vital signs stable

(2) No nausea or vomiting

(3) No undue pain

(4) Minimal or no drainage is seen on dressings

(5) Patient can ambulate

(6) Patient can tolerate fluids

(7) Responsible adult is available to transport and remain with patient overnight

c. Conduct post-operative training and provide patient with appropriate post-operative literature.

d. Advise patient to call the WBAMC Emergency Room during non-duty hours, or the ASNU during duty hours, should questions or problems arise.

e. When discharge order is written, assist patient in dressing as required.

f. Instruct family member to present any prescriptions to the main pharmacy prior to discharge.

g. Escort patient to appropriate hospital entrance. Patients may pay their bill at the Treasurer's Office at this time if they desire. NOTE: All patients other than infants/small children should be taken to the discharge point in a wheelchair.

h. Notify PAD of discharge of patient.

i. Make followup phone call the day following surgery.

5. Physican:

a. Conduct post-operative physical examination of patient.

b. Write discharge note and provide patient with any required drug prescriptions.

c. Emphasize any post-operative precautions deemed necessary.

6. Ward 10E Secretary:

Transfer ambulatory surgery patient records to PAD in accordance with existing procedures for other inpatient records.

APPENDIX F

Proposed Schedule X

MANPOWER SURVEY REPORT -SCHEDULE X - MANPOWER AND WORKLOAD DATA

For use of this form, see AR 570-4; the proponent agency is DCSPER.

REQUIREMENT CONTROL SYMBOL CSGPA-1302

MAJOR STAFF ELEMENT	DIVISION	BRANCH	SECTION OR UNIT	SHEET NO.	LINE NO.
Professional Services	Dept of Nursing	Med/Surg Nursing	Ward 10 ASNU		

DESCRIPTION OF WORK PERFORMED

Provides nursing care to patients treated in the Ambulatory Surgery Program. Patients will be of all ages, and will undergo general anesthesia in the majority of all cases. Nursing personnel will process the patient for surgery, provide post-anesthesia recovery when patient is returned to the ward, and will conduct patient instruction.

YARDSTICK CODE: Local Appraisal

WORK UNIT: Occupied Bed Day

SECTION A - SUMMARY OF MANPOWER

	OFF a	WO b	ENL c	US CIV d	NON-US CIV e	TOTAL MANPOWER SUBJ TO ALLOC f	OTHER MANPOWER US g	OTHER MANPOWER NON-US h	TOTALS i
1. ALLOCATION									
2. ACTUAL STRENGTH									
3. RECM BY CO	1			3		4			
4. RECM BY SURVEY TEAM									

YARDSTICK ALLOWANCE COMPUTATION

SECTION B - PERFORMANCE DATA

YEAR AND MONTH 19__ a	MANPOWER AVG STR b	MANPOWER TOTAL MAN-HOURS WORKED c	MANPOWER HRS OP IN MO d	MANPOWER EQUIV MAN-MONTHS (c ÷ d) e	WORKLOAD NO. OF WORK UNITS f	WORKLOAD W/L PER PERSON (f ÷ e) g
1 mo					100	4
2 mo					100	4
3 mo					100	4
1. WORKLOAD USED AS BASIS OF APPRAISAL					100	
2. AVERAGE PRODUCTIVITY						25

3. MANPOWER ALLOWANCE

SURVEY WORKLOAD (1) / AVG PRODUCTIVITY (2) = (100 / 25) = 4 × 1.11 = 4.4

SECTION C - MANPOWER

ALLOC STR a	RANK OR GRADE b	ACTUAL STR c	RANK OR GRADE d	JOB TITLE e
1	03			Head Nurse
2	GS			Nursing Assistant
1	GS			Medical Clerk

AMS CODE: SEE TDA Sec II

TDA PARA: SEE TDA Sec II

DA FORM 1 NOV 73 140-4

PREVIOUS EDITIONS OF THIS FORM ARE OBSOLETE.

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SECTION D - SPECIFIC REMARKS

COMMANDER

1. Local appraisal must be used since no similar unit exists within the Army.

2. a. Ward 10 ASNU will be located on Ward 10 East, but will be providing a distinctly separate mission from this ward's existing mission which will continue. ASA Class I and II patients requiring certain minor/elective procedures would be treated on an outpatient basis. Following referral into the ambulatory system by the physician, Ambulatory Surgery Nursing Unit (ASNU) would assume the coordinating, processing, second stage post-operative recovery, and patient teaching missions. Existing equipment and facilities would be used. The unique feature of this system is that certain pre-operative and post-operative functions would be accomplished on an outpatient basis, thus freeing existing nursing staff to care for more complicated cases. As noted in Section B, approximately 1,200 patients per year are projected for this mode of treatment. This represents a very conservative estimate, and would be expected to increase once the program becomes well established.

b. The ASNU would be operational Monday thru Friday from 0700-1630, with surgical procedures being accomplished from approximately 0800-1200. This will allow sufficient time for post-anesthesia recovery and discharge the same day. Unexpected complications would result in the patient being transferred to the appropriate surgical ward.

c. Although these patients are treated on an outpatient basis, a formal admission would be required. This is considered necessary for workload accounting purposes. Precedence for this admission policy is the ambulatory surgery program at Walter Reed Army Medical Center.

d. While the patient will be in the hospital only a short time, it is a very intense time since those functions previously conducted over a course of two to three days will now be done in a matter of hours. The patient is required to take on additional responsibility for self-care and will require additional counseling and teaching. The civilian sector has learned that the presence of registered nurses is vital to the successful operation of an ambulatory surgery program. It is imperative that the WBAMC ASNU be directly supervised by a registered nurse. Additionally, a specific request for civilian nursing assistants is made in order to provide continuity to the program.

3. The proposed responsibilities for each of the requested positions are as follows:

a. HEAD NURSE - Responsible for the operation and administrative management of the ASNU. Coordinates the goals and objectives of the unit with the Ambulatory Surgery Steering Committee and the Department of Nursing. Insures the smooth and efficient flow of the patient through the ambulatory surgery system. Introduces and establishes new procedures, routines, and/or policies as indicated. Coordinates unit operations with referring clinics, Anesthesia Office, Operating Room, and other services as needed. Interprets, clarifies, and executes orders of medical officers. Evaluates nursing effectiveness and makes appropriate changes when required. Insures that an effective patient teaching program is conducted. Plans and conducts appropriate inservice training.

b. NURSING ASSISTANT - Performs a variety of complex nursing care tasks involving extensive standardized procedures requiring knowledge and consideration of specific patient conditions and treatments. Prepares the patient for surgery and provides routine pre- and post-operative patient instruction as directed by the Head Nurse. Performs assigned housecleaning tasks. Escorts patients to appropriate hospital exit when discharged.

c. MEDICAL CLERK - Performs receptionist, recordkeeping and clerical duties related to patient treatment in the ASNU. Coordinates scheduling of the patient into the ASNU with referring clinics. Assembles and maintains patient records in the prescribed format. Coordinates admissions and discharges with Patient Administration Division. Checks contents of medical records to insure completeness prior to anesthesia interview, surgery, and discharge of patient. Prepares discharge paperwork for patients including making followup appointments, preparing clearance sheets, prescriptions, and gives necessary directions to the patient. Type necessary reports, correspondence, or time schedules as directed by the Head Nurse. Performs other clerical duties as directed.

BIBLIOGRAPHY

Books

American Hospital Association, Productivity Improvements in the Operating Room: An Examination of Case Studies. Chicago, Ill, American Hospital Association, 1981.

Drucker, Peter F. Managing in Turbulent Times, New York: Harper and Row Publishers, 1980.

Grubb, Reba Douglas, Ondov, Geraldine. Planning Ambulatory Surgery Facilities. St. Louis: Mosby, 1979.

Joint Commission on Accreditation of Hospitals. Accreditation Manual for Hospitals, 1982 edition. Chicago, Ill, 1981.

O'Donovan, Thomas R. Ambulatory Surgery Centers Development and Management. Germantown, Md: Aspen Systems Corp. 1976.

Same Day Surgery. Successful Management of Ambulatory Surgery Programs. Atlanta, GA: Same Day Surgery. 1981.

Periodicals

"ACS Reports." Bulletin of the American College of Surgeons 66 (November 1981):

Barron, E., Knoble, J.K. "Ambulatory Surgery Offers Quality Savings." Hospitals 54 (February 1980): 74-6.

Bartlett, M.K. et al. "The Role of Surgery on Ambulatory Patients in One Teaching Hospital." Archives of Surgery 3 (March 1979): 37-8.

Barton, M. Dennis. "Outpatient Surgery and Anesthesia. Primary Care 4 (March 1977): 183-97.

Berkoff, Marlene J. "Planning and Designing Ambulatory Surgery Facilities for Hospitals." The Journal of Ambulatory Care Management 4 (August 1981): 35-51.

Berkowitz, Eric N. "Marketing Ambulatory Care Centers: Planning Considerations and Demand Analysis." The Journal of Ambulatory Care Management 4 (August 1981): 51-2.

Berkowitz, Eric N., Flexner, William A. "The Marketing Audit: A Tool for Health Service Organizations." Health Care Management Review (Fall 1978): 51-2.

Burn, J.M. "A Blueprint for Day Surgery." Anaesthesia 34 (Sep 1979): 790-805.

Burns, Linda., Ferber, Mindy S. "Ambulatory Surgery in the United States: Development and Prospects." The Journal of Ambulatory Care Management 4 (August 1981): 1-13.

Burns, Linda., Ferber, Mindy S. "Survey Indicates Extensive Ambulatory Surgery by Hospitals." Hospitals 35 (July 1981).

Buske, S.M. "Audit: A Tool for Quality Assurance." Same Day Surgery 4 (April-May 1980): 30-2.

Camp, Margaret. "A Change to Primary Care in Day Surgery." AORN Journal 34 (August 1981): 342-8.

Cobb-Gerhart, Victoria; Carter, Manes G.; Gergis, Sami D. "Outpatient Anesthesia." Journal of Iowa Medical Society (June 1979): 233-5.

Cooper, Philip D.; Maxwell, Richard B.; Kehoe, William J. "Entry Strategies for Marketing in Ambulatory and Other Health Delivery Systems." The Journal of Ambulatory Care Management (May 1979): 47-54.

Cox, Susan Ann. "Perioperative Nursing in the Ambulatory Setting." Point of View 18 (October 1981): 4-7.

Davis, E. et al. "An Inside Look at Nursing in Outpatient Surgery." RN 42 (May 1979): 38-43.

David, James E. "Developing the Ambulatory Surgery Unit: The Physician's Responsibility." The Journal of Ambulatory Care Management 4 (August 1981): 27-34.

DeCerce, Jack, Reiss, John B. "Short-Stay Unit Serves Overnight Medical and Surgical Patients." Hospitals (September 16, 1981): 141-3.

"Demand Forecasting Useful to Analyze Primary Care Market." Outreach2 (September/October 1981): 2-4.

"Discharge Planning Checklist Boosts Facility's Effectiveness." Same Day Surgery 4 (February/March 1980): 21-3.

Dwoney, Gregg W. "Outpatient Surgery: If You Can't Beat It, Join It." Modern Hospital 120 (June 1973): 88-9.

Epstein, Burton S.; Coakley, Charles S.; Levey, Marie-Louise. "Outpatient Surgery - Guidelines for Organization of Unit and for Selection of Patient and Surgical Procedure." Hospitals 47 (September 1973): 80-2.

Evans, R.G., Robinson, G.S. "Surgical Day Care: Measurements of the Economic Payoff." Canadian Medical Journal 123 (November 8, 1980): 873-880.

Ford, J.L. "Outpatient Surgery: Present Status and Future Projections." Southern Medical Journal 71 (March 1978): 311-15.

Grossman, Randolph M. "Is Ambulatory Surgery Less Expensive?" Hospitals J.A.H.A. 53 (May 16, 1979): 112-13.

Hawthorne, Douglas D. "Management Forum: Promoting Your Facility to Physicians." Same Day Surgery (July 1979): 20-21.

Hawthorne, Douglas D. "Management Forum: Patient Responsibilities." Same Day Surgery (May 1979): 56-7.

Hawthorne, Douglas D. "Presbyterian Hospital of Dallas: An Ambulatory Surgery Program." The Journal of Ambulatory Care Management 4 (August 1981): 53-60.

Hoffman, George L. "Quality Control in Ambulatory Surgery." Bulletin of the American College of Surgeons 66 (November 1981): 6-8.

"HMO Study Highlights Benefits of Same Day Surgery." Same Day Surgery 4 (June 1980): 48-50.

"How to Prove Your Facility is a Community Cost Saver." Same Day Surgery 3 (December 1979): 141-4.

Hutchison, Margaret G. "Setting Up a Day Surgery Program." Dimensions in Health Service 56 (April 1979): 19-21.

Knapp, M. Robert. "Ambulatory Surgery." Medical Group Management (September/October 1979): 51-8.

Knapp, M. Robert. "The Wichita Minor Surgery Center: Perspective of the Independent Free-Standing Surgery Center." The Journal of Ambulatory Care Management 4 (August 1981): 75-84.

Knapp, S.K. "Inservice Plans for Outpatient Surgery Units." AORN Journal 30 (November 1979): 876-80.

Kohlman, Herman A. "Hospital is a Proper Focal Point for Short-Stay Surgery." Hospital Financial Management 4 (June 1974): 22-5.

Koncel, J.A. "Ambulatory Surgical Center Lowers Costs, Not Services." Hospitals, J.A.H.A. 52 (October 1978): 101+.

Lee, Rose Marie. "Day Surgery Has Added Benefit for Children." AORN Journal 19 (March 1974): 632-5.

Lieberman, Samuel L.; Biacoia, Esther B.; Fedak, Michael. "Hospital-Based Outpatient Surgery, Anesthesia Experiences." New York State Journal of Medicine 75 (February 1975): 437-440.

Luft, Harold S. "Benefit-Cost Analysis and Public Policy Implementation: From Normative to Positive Analysis." Public Policy 24 (Fall 1976): 437-62.

Maher, James W. "Crouse-Irving Memorial: A Free-Standing Surgery Center That Exceeds Expectations." The Journal of Ambulatory Care Management 4 (August 1981): 61-73.

Maher, James W. "Unit Improves Surgical Costs and Utilization." Hospitals 54 (September 16, 1980).

"'Marketing' Not 'Advertising' Advised for Same-Day Unit." Same Day Surgery 3 (January 1979): 13-15.

Marks, Sylvia D. et al. "Ambulatory Surgery in an HMO - A Study of Costs, Quality of Care and Satisfaction." Medical Care 18 (February 1980).

Maun, Patricia. "Primary OR Nursing in Outpatient Surgery." AORN Journal 29 (June 1979): 1231-1249.

Moore, J.C. "Establishment of an Outpatient ENT Clinic." AORN Journal 31 (March 1980): 620, 623, 626, passim.

Natof, H.E. "Complications Associated with Ambulatory Surgery." Journal of the American Medical Association 24 (September 5, 1980): 1116-18.

Natof, H.E. "Outpatient Surgery an Alternative." AORN Journal 29 (March 1979): 659-62.

Newman, A.B. "Planner Advises on Hospital Unit Development." Same Day Surgery 2 (January 1978): 13-14.

O'Donovan, Thomas R. "Costs of Services in Ambulatory Surgical Facilities." The Journal of Ambulatory Care Management 2 (November 1979): 23-8.

O'Donovan, Thomas R. "The Dynamics of Ambulatory Surgery." Hospital Administration 20 (Winter 1975): 27-39.

Orman, M. "Ambulatory Surgery: Its Time is Now." Today's OR Nurse 1 (November 1979): 22-7.

Phalen, James F. "Planning a Hospital-Based Outpatient Surgery Program." Hospital Progress 57 (June 1976): 64+.

"Proper Diagnosis and Treatment Aided by Outpatient Arthroscopy. Same Day Surgery 5 (August 1981): 101-2.

Selman, J.E. "OR Nursing and Ambulatory Surgery." AORN Journal 29 (March 1979): 663-8.

Shaw, L.M. "Designing an Outpatient Surgery Program." AORN Journal 31 (April 1980): 900, 902, 906 passim.

Stelling, Linda C., Zauder, Howard L. "Outpatient Surgery." Texas Medicine 70 (August 1974): 61-3.

Stevenson, B. "Granada Hills Center Offers Oncology Program." Same Day Surgery 2 (May 1978): 81-4.

"Tremendous Growth Predicted in Ambulatory Surgery." Same Day Surgery 5 (November 1981): 137-40.

"Veterans Administration Supports Same-Day Concept" Same Day Surgery 1 (November 1977): 97-8.

Wright, W.H. "Outpatient Surgery - an Alternative to Hospitalization." A.A.N.A. Journal (American Association of Nurse Anesthetists) 46 (April 1978): 135-43.

Government Publications

William Beaumont Army Medical Center Pamphlet 570-4, Manpower Procedures Handbook (10 October 1978).

Other

Alba, R. Lieutenant Colonel. Chief of Manpower/Surbey Staffing Guides Branch, Force Development Division, Health Services Command. Presentation to Ambulatory Patient Care Conference, Fort Sam Houston, Texas, March 31, 1982.

Berkowitz, Eric N. Presentation given the American Hospital Association Seminar titled, "Ambulatory Surgery: Implementing and Managing a Successful Hospital Program." Minneapolis, MN, October 29, 1981.

Baader, Marilyn ... October 29, 1981.

Camp, Margaret L. ... October 29, 1981.

Ferber, Mindy S. ... October 29, 1981.

Haussman, R.D. Dieter ... October 30, 1981.

Hawthorne, Douglas ... October 30, 1981.

Kraft, Richard O. ... October 29, 1981.

Freiheit, Gene A. Ambulatory Care Division, U.S. Army Health Services Command, Fort Sam Houston, Texas. Various telephone conversations during the months of October/November 1981.

Earnest, Ralph, Lieutenant Colonel, Chief Intensive Care Nursing Section, WBAMC, El Paso, Texas, Interview, January 27, 1982.

Elteto, Aron, Major, Chief of Anesthesiology and Operating Room, WBAMC, El Paso, Texas, Interview, March 18, 1982.

Herman, James W. Colonel, Chief of Operating Room Nurse Section, WBAMC, El Paso, Texas, Interview, January 22, 1982.

Lenneville, Mark, Captain, Ambulatory Surgery Unit Administrator, Walter Reed Army Medical Center, Washington, D.C. Telephone conversation, March 8, 1982.